University of Alberta

The Postmodern Cultural Clinic: Medicine, Femininity and Foucault

by

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Abstract

The Postmodern Cultural Clinic: Medicine, Femininity and Foucault analyzes the increasing convergence of medicine and feminine aesthetics in contemporary culture. Chapter One explores Michel Foucault's historical analysis of modern medical epistemology in *The Birth of the Clinic*. Working from a critical feminist perspective, I argue that a new spatialization of the clinic is emerging in social discourses of medicine and femininity, which simultaneously expands and reinforces medical authority over the female body. This postmodern cultural clinic elides the constraints of femininity through a rhetoric of empowerment, identity and health. Medical knowledge blurs with normative femininity, and women's individual practices of an altered medical gaze produce disciplinary clinical space.

Three case studies illustrate this clinical discourse. Chapter Two analyzes medical protocols for the inpatient treatment of anorexia nervosa. Beyond their use in treatment, these protocols materialize an explicit territory of the "clinic," in which traditional medical authority invokes a disciplinary Panopticon that seeks to return the individual to broader social panopticism. These treatment regimes produce a discursive "prison," its anorexic "patient/prisoner" disciplined through medicalized mechanisms of surveillance and routinization.

Chapter Three examines Oprah Winfrey's multi-media campaign for women's embodied empowerment. Presented as a kind of contemporary "everywoman," Winfrey carefully situates herself as an exemplar of weight loss and personal transformation, serving as proxy for her loyal viewers' own

transformations. Winfrey's ongoing weight loss campaigns signify "fat" as unhealthy, a source of national shame, a symbol of trauma, and the veil women must lift in order to "live their best lives."

Chapter Four analyzes the pro-anorexia movement, an internet-based movement that advocates anorexia as a legitimate lifestyle. Its discourse produces a virtual clinic by which the participants in the movement evade medical authority and usurp the medical gaze, at once deliberately manipulating medical discourse and falling prey to its regulatory impulses. With the anorexic body signifying disease and disgust, pro-anorexic exclusion from mainstream culture paradoxically reiterates this disdain; its participants enter the disembodied space of the internet to rid themselves of the bodies with which they struggle, but they ultimately fail to escape the prison of the unruly female body.

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Introduction

Almost forty years after "Twiggy" became a beauty icon, the thin feminine aesthetic still afflicts women. In the contemporary moment, though, it exacts a thinner, fitter female form, at once demanding increased commitment and pushing the possibility of success further out of reach. Hegemonically marked by "whiteness," affluence, youth and hetero-desire, the regulatory impulses of this aesthetic measuring stick are now mediated through the increasing convergence of medicine and beauty. BMIs, fat grams, exercise regimes and diet plans merge the authoritative weight of medicine with the cultural demand for feminized thinness, sharpening the punitive/productive disciplinary force of femininity with the medical impetus of "health."

This convergence signals the space of the postmodern cultural clinic, an emergent clinical discourse that both informs and materializes contemporary feminized identity. I theorize this discourse through the writings of French philosopher Michel Foucault and primarily his early text *The Birth of the Clinic: An Archaeology of Medical Perception.*[1] In *The Birth of the Clinic*, Foucault analyzes the historical development of modern medical epistemology in eighteenth and nineteenth century France. He details the emergence of the core concepts of medical knowledge: the gaze, the clinic, pathological anatomy, the medical exchange. He traces the complex transition from a medieval medicine of symptoms and humours to one in which the legitimized authority of medical vision wields the power to separate the normal from the pathological and to uncover the mysteries of the living in the bodies of the dead. This transition signals, as well, the expansion of medical vision from a discrete focus on individual bodies to the social space between bodies,[2] expanding in turn its disciplinary role in the lives of women.

Today, this apparatus of power/knowledge emerges in the convergence of medicine and feminine aesthetics. The postmodern cultural clinic synthesizes the multiple and contradictory demands of normative femininity, and thereby insidiously incorporates the vision of the medical gaze into feminized identity. I analyze the discursive and material parameters of this cultural clinic in order to expose the struggles over femininity that are being played out on women's bodies—and often at their expense. I first detail the theoretical framework of the postmodern cultural clinic, and then examine three case studies that illustrate its discursive manifestations: the medical protocols for the inpatient treatment of anorexia nervosa; Oprah Winfrey's multi-media discourse on weight loss; and, the internet-based pro-anorexia movement.

Cultural dichotomies of "fat" and "thin," embodied empowerment and disciplinary constraint, desire and disdain are inscribed in these cultural spaces. Each case study spatializes the postmodern cultural clinic in particular ways and exposes women's complex negotiations with the now entangled regimes of health and beauty. Seemingly mundane cultural milieux of bathroom stalls, grocery store check-out lines, school lunch rooms and beauty salons materialize these struggles. Everyday exchanges signal this feminized angst: a fellow parent at a school function asks advice on her daughter's weight obsession (as long as her daughter stays thin); family friends rant about Oprah's ongoing weight loss diatribe, but faithfully count "points" and fat grams; students defend diet and exercise regimes as "healthy," but follow them with religiously fervent devotion; minute graffiti in a bathroom stall hails "is anyone out their pro-ana?" This project was instigated by such moments, and by conversations with friends and colleagues about the ever-expanding demands on women's bodies, identities and time. I was continually struck by the painful resonance between the culturally constituted desire to be thin and medically sanctioned reasons to do so. How does "health" at once signal embodied empowerment and endlessly embroil women with the disciplinary regimes of normative femininity? What prompts and sustains the paradoxes of contemporary feminized identity—the envy and revulsion at stories of women involved with anorexic practices, the attentive disdain for "celebrity" thinness, the practiced ambivalence of the girls in my son's elementary school class whose confidence gives way under the ever-changing boundaries of growing, maturing, pre-teenaged bodies?

Marked at once by shame and desire, these paradoxes permeate everyday life; pass any billboard, read any women's magazine, turn on *Entertainment Tonight* or *Nip/Tuck*, and the convergence of health and beauty seems obvious. The contemporary cultural messages of feminine beauty are as infused with notions of health as is health signified by a particular (though ever-changing) aesthetic. What is revealed, though, when this collision is examined beyond the superficial? What happens when we take it seriously? What is exposed when the power/knowledge apparatuses informing anorexic inpatient treatment are acknowledged, when a talk show is understood as cultural discourse, or a subversive website read as legitimate cultural text? More to the point, what is concealed when we dismiss these texts as superficial, vanity-induced noise?

In the spatializations of the postmodern cultural clinic, how is the medical gaze incorporated into feminized identity, and when is it brought to bear? Put another way, how does this gaze insinuate itself into the power/knowledge apparatuses of normative femininity and into individual women's lives? As a subjectifying practice, how does it operate? Can the healthy ideal even be separated from the thin aesthetic; or, is this a specious suggestion? Perhaps more important than the minutiae of these questions, what do the processes of the postmodern cultural clinic reveal about women's subjectification and embodied experiences in contemporary culture? And, how do the examples of anorexic inpatient treatment, Oprah's weight loss discourse and the pro-anorexia movement materialize this clinical discourse?

To explore these questions, I undertake a discursive and textual analysis of these cultural sites. The anorexic inpatient protocols are texts taken from medical books and journals.[3] Official transcripts from *The Oprah Winfrey Show*, articles and covers from *O: The Oprah Magazine*, and pages from the official *Oprah Show* website make up Oprah's weight loss discourse. And, the constantly shifting websites of the pro-anorexia movement are the primary representations of this internet subculture. These texts cross-produce the various discursive manifestations of the postmodern cultural clinic.

Dorothy E. Smith articulates a methodology of textuality that I find useful for discussing such diverse cultural texts as a corpus. In her institutional ethnography, Smith suggests that texts are representative of the hegemonies of institutions.[4] She argues that the intersection of everyday local settings and abstracted, extra-local ruling relations is mediated by the materiality of printed and electronic texts. The texts integral to the social organization of these forms are complemented by technologies or disciplined practices that produce standardized local states of affairs or events corresponding to standardized text.[5] As Smith states, "texts are the mediators and bases of discourses and ruling relations that regulate and coordinate beyond the particular local setting of their reading or writing."[6] Texts, in other words, connect the abstractions of dominant social discourse with the particularities of individuals' everyday realities.

In this project, I am particularly interested in exposing the dominant social discourses that are embedded in the postmodern cultural clinic. The texts of the inpatient protocols, Oprah Winfrey's multi-media campaigns, and the pro-anorexia websites reveal the "ruling relations" embroiled with their cultural production. Women's engagement with them—as patients undergoing treatment, television viewers, magazine readers, internet users—enables the production and reiteration of these power/knowledge apparatuses. As texts, they mediate the discursive convergence of medicine and feminine aesthetics within the postmodern cultural clinic.

Following Smith, I believe that disentangling the ruling relations of social institutions involves multiple projects that analyze the different, but interconnected, parts of discourses.[7] Therefore, this analysis addresses certain aspects of the complex discourse of women's struggles with embodied femininity, a discourse that is simultaneously comprehensive and incomplete; and, I leave women's particularized engagements with the texts of the postmodern cultural clinic for a future project. In this work, each case study reveals particular aspects of the postmodern cultural clinic; and, differences between these sites are materialized through their particular disciplinary and regulatory practices, their particular mediations of the medical gaze, and their particular means of surveilling the female body. I read each site as a discrete "clinic" that gives way to a broader, though still fraught, discourse of normative femininity. The formal institutionalized discourse of anorexic inpatient protocols represents a precise and narrow expression of the postmodern cultural clinic, a literal clinical space insidiously suffused by the discursive apparatuses of normative femininity. Oprah's weight loss discourse expands the medical call for "health" into familiar televisual space, harnessing its disciplinary impetus via Oprah's multiple messages of individual responsibility and self-transformation. And, the pro-anorexia movement blatantly refutes medical authority, abandoning the traditional confines of the clinic in order to manipulate the terms by which pro-anorexic embodiment is disdained.

I also take up Smith's textual approach as it engages the politicized tensions and contradictions of embodied femininity, and locates text in the intersections of regulatory regimes and individual experience. It acknowledges the role of text as a mediator between discursive apparatuses and actual individuals.

On this point, Smith's approach responds to a key criticism of Michel Foucault's work—the charge that Foucault's analyses generalize or abstract particular historical relations and specifically lack a substantive gendered perspective that interrogates the politicized realities of women's lives.[8] While his theories of discipline, power, sexuality and medicine are now routinely taken up by feminist scholars,[9] this critique suggests that Foucault's analyses trace these discursive forms rather than undertaking a sustained critical interrogation of their impacts. For instance, *The Birth of the Clinic* offers few references to women, and those that are offered reflect the masculinist tradition from which modern medical epistemology extends.[10] Foucault considers neither the discursive pathologization of "woman" nor the material denigration of particular women under medical regimes. This absence can be interpreted as a reflection of the texts with which Foucault works, a failing, then, not of his archaeology of medical perception but of medical perception itself. However, it can also be read as Foucault's failure to engage with the broader social, cultural and political discourses within which modern medical epistemology developed. By contrast, Smith's methodology continually situates texts within such contextualizing frameworks.

Yet, Smith's textual approach also resonates with Foucault's archaeological and genealogical analyses of discursive forms via historical texts, and with the partiality of textualized discourses and knowledges. Foucault argues that we must "address 'practices' as a domain of analysis, and approach the study from the angle of what 'was done'."[11] He argues that "one needs to study what kind of body the current society needs" in order to reveal the mechanisms of power at work in a particular sociohistorical moment.[12] And, to do so, "one must have at one's disposal the general archive of a period at a given moment."[13] This approach provides a mechanism of sorts for locating discursive elements. As Foucault states, genealogy "must record the singularity of the events outside any monotonous finality; it must seek them in the most unpromising places, in what we tend to feel is without history . . . it must be sensitive to their recurrence, not in order to trace the gradual curve of their evolution, but to isolate the different scenes where they engaged in different roles . . . [and] genealogy must define even those instances where they are absent."[14] This is not about "origins," metanarratives or essences, but instead about the particularities embedded in the descent of discursive forms, "the accidents, the minute deviations—or conversely, the complete reversals—the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us."[15] As C. G. Prado suggests, Foucault's approach is about the "conceiving of micro-particulars as components of some broader process."[16] While I am not undertaking a genealogical investigation, I adhere to the idea that the analysis of particular texts, practices and illustrative examples reveals something of the power/knowledge apparatuses with which they are entwined, a perspective that aligns with Smith's partiality of knowledge and with her textual methodology.

Chapter One, "The Postmodern Cultural Clinic," begins with and expands Foucault's historical analysis of modern medical epistemology in *The Birth of the Clinic*. Reading through Foucault's works on discipline and power, and through feminist theorizing on embodiment, I critique Foucault's analysis of the emergence of modern medicine and interrogate the power relations with which it is embedded. I argue that a new spatialization of the clinic is emerging in the social discourses of medicine and femininity, which simultaneously expands and reinforces medical authority over the female body. The often paradoxical negotiations of women's embodied identities are entwined with this emergent clinic. The postmodern cultural clinic elides the traditional constraints of femininity through a rhetoric of empowerment, identity and health. Medical knowledge blurs with normative femininity, and women's individual practices of an altered medical gaze produce disciplinary clinical space.

Working from a critical feminist perspective, I specifically argue that disciplinary apparatuses and social regulation converge in the non-reciprocity of the clinical exchange to produce the normalizing impulse of the postmodern cultural clinic. While conventionally understood as a discrete and literal space, the "clinic" is displaced in this process, materializing instead in the various subjectified spaces of women's embodied practices, as well as in cultural texts and sites. The medical gaze mediates this displacement, both as a now altered gaze inextricably entwined with the multiple gazes of contemporary social life and as a disciplinary mechanism incorporated into feminized identity. The postmodern cultural clinic emerges in each feminized disciplinary practice, and each individual practice spatializes the disciplinary impetus of medical authority into popular culture, bodies and texts, the apparatuses of normative femininity and the psyche of the individual woman.

From this theoretical framework, I move to the three case studies. In Chapter Two, "Re/forming the Anorexic 'Prisoner'," I analyze medical protocols for the inpatient treatment of anorexia nervosa. Beyond their use in treatment, these protocols materialize an explicit territory of the "clinic," in which more traditional forms of medical authority invoke a disciplinary Panopticon that seeks to return the individual to the broader panopticism of the social world. I argue that these treatment regimes produce a discursive "prison," its anorexic "patient/prisoner" disciplined through medicalized mechanisms of surveillance and routinization.

Chapter Three, "Weighing in on Oprah," examines the televisual clinical space of Oprah Winfrey's multi-media campaign for women's embodied empowerment. Presented as a kind of contemporary "everywoman," Winfrey carefully situates herself as an exemplar of weight loss and personal transformation, serving as proxy for her loyal viewers' own transformations. Winfrey's ongoing weight loss campaigns signify "fat" as unhealthy, a source of national shame, a symbol of trauma, and the veil women must lift in order to "live their best lives." This multiplicitous articulation links the thin aesthetic to conventional discourses of health and beauty, and reinforces medical authority over the appropriately controlled female body.

Finally, in Chapter Four, "Pro-Anorexia: Crossing the Virtual Line," I analyze the discourse of the pro-anorexia movement, an internet-based movement that advocates anorexia as a legitimate lifestyle and identity choice. This discourse produces a virtual clinic by which the participants in the movement evade medical authority and usurp the medical gaze, at once deliberately manipulating medical discourse and falling prey to its regulatory impulses. With the anorexic body signifying disease and disgust, pro-anorexic exclusion from mainstream culture paradoxically reiterates this disdain; its participants enter the disembodied space of the internet to rid themselves of the bodies with which they struggle, but they ultimately fail to escape the prison of the unruly female body.

Tensions between agency and constraint, empowerment and complicity, desire and revulsion run throughout these three examples, revealing the complex, and often contradictory, messages of normative femininity. The ongoing negotiation between individual disciplinary practices and regulatory regimes, between the intimate and the abstract are also at play. A strange paradox emerges in which individual women's identities are simultaneously central to and absent from these texts, paralleling the textual mediation between the specificities of individual women's experiences and the power/knowledge apparatuses that inform them. The abstracted "patient" is, for instance, the obvious focus of the inpatient treatment protocols for anorexia nervosa, but the presence and voice of individual women *as* patients is missing. Given that these particular texts are directed to medical professionals, the enacted protocols would presumably uncover the lives of the women to which they are applied, but discussion of these women is largely absent from the medical protocols I examine. In Oprah Winfrey's televisual discourse, individual weight struggles are translated to universal experience. Winfrey's own carefully crafted public persona is premised on her troubled personal history as a single, African-American woman from humble roots and as a woman whose weight struggles have become public territory; and, Winfrey regularly reveals "personal" information to her audience in order to produce an intimate connection with her viewers and to ensure her position as a modern-day "everywoman." Her audience is constructed as both diverse and homogeneous, their diversity reflecting Oprah's broad appeal and their homogeneity demonstrating the cohesiveness of her message. In the virtual space of the internet, pro-anorexic participants are anonymous and pseudonymous: they conceal themselves while revealing intimate details of their daily lives, in an effort to efface their own identities for the all-consuming identity of "Ana" and to erase the bodies with which they struggle. Across these case studies, this paradox of intimacy and nebulousness serves to entrench the regimes of the postmodern cultural clinic: nebulousness ensures their broad appeal and intimacy breeds the familiar. As a result, individual women's specificities slip from view and the thin feminine aesthetic, along with the postmodern cultural clinic, are reiterated as hegemonic cultural forms.

As women's social power has expanded in recent decades, however, the thin aesthetic has come under increasing scrutiny; women's agency, empowerment and "choice" have unsettled blind adherence to its demands. Yet, when co-opted into medical discourse, this aesthetic is disturbingly recuperated in the discourse of the postmodern cultural clinic, though often only temporarily. On the one hand, this co-option expands the force of the thin aesthetic, with waist circumference, body fat and BMI each signifying "health" in the shadow of the "obesity epidemic." On the other hand, this co-option shifts attention away from the punitive force of the thin feminine aesthetic as a subjectifying mechanism deeply embedded in social hierarchies of "race," class, heteronormativity and ability. The icon of contemporary "western" beauty is still the white, affluent symbol of hetero-desire; but, she is now also thin, fit, and "healthy." This recuperation does not, then, signal any substantive change. The thin feminine aesthetic is still a means by which to ensure women's daily, disciplined adherence to the shifting, though hegemonic, standards of normative femininity, an adherence now sharpened under the guise of "health."

Notes

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[1] Foucault, *Birth of the Clinic*.

[2] Armstrong, *Political Anatomy*, 6.

[3] In my analysis of the pro-anorexia movement, I chose not to participate in pro-anorexia chatrooms, electronic bulletin boards and list serves, or to analyze their content. This may be seen as a weakness or gap in my analysis. Ethically, though, I could not ensure the permission of participants, as most use pseudonyms and participate in these forums precisely because they are anonymous. Further, anti-pro-anorexia advocates, researchers and media suspect that many participants are underage. This kind of analysis would have involved gaining permission from parents or guardians, and most participants hide their practices and participation in the movement from their families. Interviewing them would have been complicated, to say the least. As well, I did not want to enter the chatrooms covertly, misrepresenting either myself or my purpose for being there. Many pro-anorexia sites state that they do not want researchers, media or anti-pro-anorexia advocates to enter or participate in their sites. I chose to respect this desire. Though my analyses of pro-anorexia websites focused solely on public domain information (e.g., URLs accessible via web browsers, and without passwords or log-ins), I submitted an application for ethics review of my work on the pro-anorexia movement to ensure the efficacy of my online research. For further details, see the University of Alberta Arts, Science and Law Research Ethics Board Certificate of REB Approval in Appendix I.

[4] Smith, "Institutional Ethnography"; and, Smith, *Writing the Social*.

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[5] Smith, *Writing the Social*, 75.

[6] Ibid., 80.

[7] Smith, "Institutional Ethnography"; and, Smith, *Writing the Social*.

[8] For example see Gremillion, *Feeding Anorexia*, 30; Harding, "Bodies at Risk"; Harstock, "Foucault on Power"; and, Watson, "Applying Foucault."

[9] At the same time several of these texts problematize as well as utilize Foucault's theoretical perspectives, see for example Bartky, "Modernization of Patriarchal Power"; Bordo, *Unbearable Weight*; Butler, *Gender Trouble*; Butler, *Psychic Life*; McNay, *Foucault and Feminism*; Ramazanoglu, *Up Against Foucault*; Sawicki, *Disciplining Foucault*; and, Taylor and Vintges, *Feminism and the Final Foucault*.

[10] In Chapter 1, "The Postmodern Cultural Clinic," I discuss modern medical epistemology further as a masculinist—and patriarchal—knowledge apparatus. For additional discussion, see also Bell, "Reluctantly Finding Woman-as-Death."

[11] Foucault, *Aesthetics*, 462.

[12] Foucault, *Power/Knowledge*, 80.

[13] Foucault, *Aesthetics*, 263.

[14] Foucault, *Language*, 140.

[15] Ibid., 146.

[16] Prado, *Starting with Foucault*, 34.

Chapter 1: The Postmodern Cultural Clinic

The appropriately disciplined contemporary woman is, if not consumed by, at least consistently attentive to bodily matters; diet plans, exercise regimes, BMIs, fat grams, carb counts, dress sizes and body weights occupy vast amounts of women's time and energy, to say nothing of their conversations with friends or random daily thoughts. To fail to demonstrate such feminized attentiveness is to risk being labelled "fat," "unattractive" and, more recently, "unhealthy." An ever-increasing plethora of body-defining practices subjectify "good" women as not only the more normatively attractive objects of hetero-desire, but also as healthy, responsible individuals. In a cultural moment besieged by fat epidemics, stomach stapling and gluttonous over-consumption, feminized bodily restraint is now infused with the rhetoric of an expanding medical discourse of "health," rewriting women's culturally constituted bodily obsessions with the authoritative gaze of medicine.

This gaze is hardly producing a reprieve for the long-suffering "female body." Instead, the female body is emerging as a site of the often contradictory and detrimental convergence of medicine and beauty. Eighty percent of North American women are on diets,[1] but they are still, on average, getting heavier.[2] Eating disorders are on the rise, while medical standards of appropriate weight are shrinking. Women are finally claiming authority over their bodies in numerous spheres of social, political and cultural life, but their daughters are dieting at increasingly younger ages.[3] Within these contradictions and tensions, a battle over the meaning of femininity is being played out on women's bodies—and often at their expense.

I suggest that the postmodern cultural clinic is the primary site of this battle. While the idea of "the clinic" conventionally evokes images of doctors' offices or hospital waiting rooms, the postmodern cultural clinic exists anywhere that the medical gaze, in Foucauldian terms, engages in a non-reciprocal exchange.[4] Instead of discrete diagnoses gleaned from the life and death of the body, this contemporary cultural clinic spatializes "disease" across cultural milieux and hegemonic ideologies; its medical object is both Foucault's social body and the embodied individual who is subjectified via disciplinary practices. Thus, this postmodern cultural clinic is at once discursive and material, theoretical and embodied. It entwines certain apparatuses of power/knowledge with normative femininity, altering and strengthening its force in the lives of women. Exploiting the symbiotic relationship between medical knowledge and the pop-cultural dissemination of images of feminine beauty, it engenders particular feminized bodily practices, bringing all women under its disciplinary scope (albeit unevenly). Foucault argues that the regulatory regimes of society produce subjects who discipline themselves and their bodies to the needs of society.[5] As an apparatus of power/knowledge, medicine is central to this process as an institution that brings its "power to bear on groups of individuals, in terms of behaviors, ways of being, acting or speaking."[6] Foucault contends that, with the rise of capitalism, "biopolitics, the biological, the somatic, the corporal [came to matter] more than anything else."[7] He adds, more pointedly, that "the body is a biopolitical reality; medicine is a biopolitical strategy."[8] Medicine, then, is one of the key disciplinary apparatuses that produce the "docile bodies" of Foucault's disciplinary society. With simultaneously punitive and productive force, it fashions and advances a set of bodily technologies, knowledges, disciplines—practices—that produce individuals disciplined toward a particular kind of social body, a social body now framed by the regulatory regimes of "health."

Feminist theorists assert that women embody such disciplining force to their detriment.[9] Sandra Lee Bartky, for instance, argues that the modernization of patriarchal power has drawn women into collusion with those same discursive forces that oppress them. She suggests that not only is normative femininity increasingly focused on women's bodies, but that women have internalized this disciplinary power, coming to police themselves as well as to derive a sense of self-mastery from their efforts.[10] As normative femininity is bound up in sociocultural ideals of thinness, youth and beauty, such self-disciplinary efforts inevitably fail, perpetuating women's efforts by returning them to ideals they have yet to achieve. And, any "successes"—inadequate though they may be—are then filtered through markers of "whiteness," affluence and hetero-desire, reinforcing the hegemonic impulses of normative femininity.

Medicine has recently widened its domain by investing the pressure for women to aspire to popular images of beauty with the authority of its professional gaze. The cultural space of medical control has merged with broader ideologies of femininity, just as the clinic has proliferated and diversified well beyond the confines of the doctor's office and is now inextricably incorporated into feminine identity. This collision of medicine, aesthetics and normative femininity reflects contemporary tensions between institutionalized authority and individual agency, disciplinary power and subjectivity, cultural notions of health and unhealthy obsessions driven by social ideals. The postmodern cultural clinic resides precisely in women's daily struggles to both meet and resist the shifting, though ever-present, ideals of thinness and health. It both relies on and enables the constitutive contradiction between women's embodied empowerment and their own collusion with the regimes that oppress them. Multiplied and diffused clinical moments emerge with every fat gram passed over and every mile logged on the treadmill, ever more elusive and more deeply embedded in women's embodied struggles with feminine identity. With this shift, I propose that the postmodern cultural clinic has replaced medicine itself as a key means of disciplining women and their bodies.

I begin by outlining the historical roots of the postmodern cultural clinic, as it both begins with and expands Michel Foucault's historical analysis of modern medical epistemology in *The Birth of the Clinic: An Archaeology of Medical Perception*. The emerging disciplinary regimes of modern society coincided with the development of medical knowledge, connecting the individual discipline of the medical gaze with broader regulatory discourses. In particular, I argue that the normalizing project of modern medicine took "man" as its model, confining "woman" to a position of abject pathologization, the imbalanced non-reciprocal exchange of the clinical moment extending the social constraints of feminized identity. I then detail the parameters of the postmodern cultural clinic.

Specifically, this clinic displaces the clinical moment into "the undifferentiated space between bodies,"[11] across cultural texts and sites, and into a space of failure. It incorporates an altered and now multiplicitous medical gaze[12] into the psyche of the individual woman. And, it spatializes normative femininity across multiple spaces and into women's practices of a re/formed feminine aesthetic, enhanced and extended by the convergence of medicine and beauty.

Birthing the Postmodern Cultural Clinic

In *Discipline and Punish: The Birth of the Prison*, Michel Foucault now famously identifies Jeremy Bentham's Panopticon as "a generalizable model of functioning; a way of defining power relations in terms of the everyday life of men [*sic*]."[13] Moreover, this Panopticon is the model upon which disciplinary society is structured.[14] While it was originally a penal model for the surveillance of prisoners, the Panopticon, with its notion of potential and continual surveillance, has been translated both to other institutional settings of explicit disciplinary control and to the more implicit power relations within society. Specifically, the Panopticon

> is polyvalent in its application; it serves to reform prisoners, but also to treat patients, to instruct schoolchildren, to confine the insane, to supervise workers, to put beggars and idlers to work. It is a type of location of bodies in space, of distribution of individuals in relation to one another, of hierarchical organization, of disposition of centres and channels of power, which can be implemented in hospitals, workshops, schools, prisons. Wherever one is dealing with a multiplicity of individuals on whom a task or particular form of behaviour must be imposed, the panoptic schema may be used.[15]

"Panopticism" is a "procedure of [the] subordination of bodies and forces" and "the general principle of a new 'political anatomy' whose object and end are not the relations of sovereignty but the relations of discipline."[16] In increasingly complex societies, it is a disciplinary mechanism which simultaneously refines and multiplies the political power at work among the individuals that constitute a society, thereby producing new forms of power/knowledge.[17] This new disciplinary mechanism thus inextricably links power, as a now diffuse and multiplicitous practice, with the apparatuses of knowledge informing social relations to produce a "micro-physics" of power.[18]

Hence, the techniques by which this process occurs both multiply and diffuse, but the most important effect of panopticism is its (re)production of "the disciplinary individual."[19] As particular forms of behaviour are both the subject and effect of this disciplinary control, "the body" is directly involved with these fields of political power. While the individual may still be coerced directly through physical violence, "discipline produces subjected and practised bodies, 'docile' bodies. Discipline increases the force of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). In short, it dissociates power from the body; on the one hand, it turns it into an 'aptitude,' a 'capacity,' which it seeks to increase; on the other hand, it reverses the course of the energy, the power that might result from it, and turns it into a relation of strict subjection."[20] Foucault concludes that "if economic exploitation separates the force and the product of labour . . . disciplinary coercion establishes in the body the constricting link between an increased aptitude and an increased domination."[21] Individuals now take up certain social standards, routines, practices, beliefs, behaviours—disciplines—as their own, ensuring their conformity to and involvement with the disciplinary regimes of their society. Panopticism—the ever-present threat of surveillance—is a means, in other words, of translating such technologies of disciplinary control into the everyday practices of the individual. In turn, disciplinary regimes become mechanisms of domination diffused throughout society and into the psyche of the individual, whereby the individual recreates these mechanisms through their own embodied practice of discipline. The idea of the Panopticon is then premised on a uni-directional gaze, yet results in the production of positive power within the body-subject of the individual through the translation of the literal Panopticon into panoptic discursive practices.

This panoptic gaze is neither uniform nor benign in its production of disciplinary individuals, however. More specifically, individual disciplinary practices entangle women with the power/knowledge apparatuses of hetero-patriarchal control. Women are at once complicit in the reproduction of their own embodied subordination and produce their feminized identities via hegemonic regimes of heteronormativity, ethno-racialization and affluence. In fact, Sandra Lee Bartky argues that what Foucault exposes as the disciplinary normalization of "man" "is perhaps even truer of 'woman'."[22] Embedded in the bodily self-disciplining of women, a process which leaves no aspect of appearance, comportment, size, shape or appetites unaltered, is the need for this discipline to result in an inferiorized feminine body-subject.[23] It is, then, not only a different gaze that is turned on women, but a distinctly different disciplinary goal that is demanded of them. A large body of diverse feminist criticism has challenged this feminized disciplinarity. Andrea Dworkin demonstrates how the totalizing and often painful technologies of feminine beauty purposefully construct women as the lesser sex.[24] Honi Fern Haber exposes normative feminine disciplines as producing distinctly submissive and weak female bodies.[25] Susan Bordo,[26] Kim Chernin[27] and others[28] reveal the devastating force of the contemporary "cult of thinness" in the lives of women. This gaze also holds the thin, young, white, heterosexual woman as its objectified ideal.[29]

The subjectifying constraint of the "cult of thinness" thus sharpens the failures of feminized identity by perpetuating this ideal through the power/knowledge apparatuses of ethno-racialization and white privilege, "western" affluence, and patriarchal hetero-desire. On the one hand, the thin feminine aesthetic homogenizes across these hegemonic discourses. Mervat Nasser asserts, for instance, that the emergence of eating disorders in non-western cultures signals an increasingly homogeneous global culture in which wealth expansion, the "McDonaldization" of diets, and the media-based "global village" are each tied to an "identification of western cultural norms in relation to weight and shape preferences for women."[30] On the other hand, the thin feminine aesthetic is diverse in its applications. As Becky W. Thompson suggests, women's eating problems are an attempt to cope with the various oppressions and traumas associated with a culturally defined feminine subjectivity. African-

American and Latina women, lesbian women and impoverished women now access the pervasive practices of "disordered eating" to mediate the socially situated stressors of their marginalized circumstances.[31] Yet, this diverse involvement insidiously reproduces the dominant discourses with which the thin feminine aesthetic is entwined. With the expansion of its individualized practices to ever-increasing groups of women and cultural contexts, the thin aesthetic simultaneously co-opts this diversity to strengthen its regulatory force. Concern over diet and discipline is no longer a "privileged" undertaking. It is marked by a homogenization of global cultures and a re-entrenchment of white, affluent, heteronormative, "western" standards of feminine beauty, both of which obscure the material differences of women's embodied struggles.

The panoptic gaze of disciplinary normalization is then not a benign gaze but, rather, one which shapes normative femininity through various heterosexist, racist, and classist oppressions. Nor is this gaze a uni-directional force imposed on "docile" bodies. Although informed by sociocultural norms of femininity, women's lived experiences reveal the complexities of femininity as a disciplinary practice, disrupting the notion that women are passive recipients of this disciplinary regulation. Indeed, many authors note the resistance and empowerment embedded in women's practices of embodied femininity.[32]

In the following chapters, I examine three case studies that reveal the complexities of femininity as a disciplinary practice: the medical protocols for anorexic inpatient treatment; Oprah's weight loss discourse; and, the pro-anorexia movement. While the precise measures of anorexic inpatient "recovery" exemplify the standards of normative femininity, individual patients often skilfully manipulate these norms. In many ways, Oprah's weight loss discourse imposes a rigid disciplinary subjectivity, yet it is suffused with the rhetoric of women's empowerment. And, the pro-anorexia movement illustrates, in excruciating detail, the constant demand to discipline the female body, while vehemently resisting the simultaneous pathologization and denigration of its participants. Such complications do not mean that normative femininity is unproblematic, but instead that its production through women's practices is at once constraining and enabling, power-laden and empowering. The disciplinary standards of normative femininity—those fleeting social ideals toward which women strive but can never reach—insidiously incorporate a certain access to power, self-expression, self-mastery and social position into women's experiences of feminine subjectivity.

Nonetheless, normative femininity, as a disciplinary mechanism of patriarchal control, becomes incorporated into and inseparable from the appropriately disciplined female body. With the diffusion of power in modern societies of normalization, though, the external impetus for this disciplining—namely, the maintenance of the gender binary hierarchy and other axes of oppression—disappears from view, as women internalize the particularly male gaze of panoptic discipline and denigrate themselves for their failure to match ideal feminine forms. Women's disciplined conformity toward such ideals makes normative femininity and its bodily representations more resistant to deconstruction, though not impossible to resist. Yet, if women challenge these standards, they challenge their own socially and culturally constituted notions of themselves.[33] They thus come to police their own conformity and penalize their own perpetual failure. As Bartky suggests,

> the woman who checks her makeup half a dozen times a day to see if her foundation has caked or her mascara has run, who worries that the wind or the rain may spoil her hairdo, who looks frequently to see if her stockings have bagged at the ankle or who, feeling fat, monitors everything she eats, has become, just as surely as the inmate of the Panopticon, a self-policing subject, a self committed to a relentless self-surveillance. This self-surveillance is a form of obedience to patriarchy. It is also the reflection in woman's consciousness of the fact that *she* is under surveillance in ways that *he* is not, that whatever else she may become, she is importantly a body designed to please or to excite.[34]

This *female* disciplinary individual is, then, always subject to the gaze of a heteronormative patriarchal Panopticon that surveys her embodied conformity more fervently than it does *man's*.

The collusion of medicine and patriarchy imbues this panoptic gaze further with the authority of medical knowledge, at once expanding and sharpening its punitive force. As a key apparatus of the modern disciplinary society, medicine's legitimized authority over not only individuals, but also broader issues of social welfare, enables it to produce bodies that are analyzed, codified, objectified—entirely revealed to the medical gaze. Medicine has been central to the identification of the madman, the hysterical woman, the Malthusian couple and the sexualized child, to the institutionalization of sexual discourses, and to the regulation of the individual in the family, school, prison and hospital.[35] Medical involvement in these institutions is premised on its authority over "a body which had no existence prior to its crystallisation in the space delineated by a monitoring gaze."[36]

In his book *Political Anatomy of the Body*, David Armstrong traces the construction of this new bodily form that was both the object and effect of medical practice. As he explains,

> late in the eighteenth century medicine began to see a body which had a new anatomy. This body appears to have been discrete because it was recorded in separate case notes; it was accessible because at this time medicine began to use methods of physical examination; it was analysable because pathology became localisable to a distinct point within the body; it was passive because the patient's personal history was relegated from its primary position as the key to the diagnosis to a preliminary; and it was subjected to evaluation because patients were moved from the natural locus of the home to the neutral domain of the hospital.[37]

With every new technique deployed and illness treated, medicine "drew an outline of a particular anatomy, a docile body."[38] Time and refinement specified this anatomy, such that "as the nineteenth century progressed each and every consultation of the new pathological medicine functioned to imprint, by its sheer repetition, the reality of a specific anatomy on a social conscience."[39] This new reality signalled the realignment of power that was to come in the twentieth century. As Armstrong concludes, "the medical gaze, which had for over a century analyzed the microscopic detail of the individual body, began to move to the undifferentiated space between bodies and there proceeded to forge a new political anatomy."[40]

The historical narrative Armstrong so eloquently delineates clearly does not differentiate the female body from the male body. However, it does reveal how medicine, as a biopolitical strategy, emerged from under this refined, yet simple, practice of the medical gaze. This gaze mediated the shift from a medicine of symptoms described by the patient to one of disease silently observed by the physician, from individual health to standards of medical normality, from the individual body to the social regulation of civil society. Yet, this expansion from individual to social space "merely extended medical surveillance into all areas of patients' lives."[41]

In its most basic articulation, the medical gaze mediates the grounding medical epistemological premise of pathologization. Endowed with the legitimized authority to separate that which is "pathological" from that which is "normal," the physician—discursively coded as male—turns his trained gaze upon the individual. If pathology is observed, the individual becomes an appropriate object for medical intervention: he or she is pathologized on the basis of disease, behaviours or practices, and is brought under medical control.[42]

Medical authority is open to question on its own given its collusion with patriarchal knowledge structures, to say nothing of the hegemonies of white privilege, European paternalism and colonial discourses advanced under the science of medicine.[43] However, in *The Birth of the Clinic*, Foucault also identifies the historical grounding of medical authority over the binary hierarchy of normal/pathological in "a knowledge of *healthy man*, that is, a study of *non-*

sick man and a definition of the *model man*. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives."[44] While Foucault does not specify a critical gendered reading of this statement, his use of "man" is hardly accidental. Developing out of Enlightenment and post-French Revolution thought, this medical standard of "model man" reiterates the patriarchal and eurocentric dualisms embedded in abstract individualism,[45] applying them not only to the individual patient but also the social body of disciplinary normalization.

Hence, this construction of "model man" epistemologically extends the binary of normal/pathological into social space, not only by emulating "the standards for physical and moral relations of the individual and of the society in which he [*sic*] lives,"[46] but also by occupying the discursive/epistemic location of "normal." "Woman," by contrast, is relegated to the position of pathology. Both historical and contemporary examples demonstrate the effects of this masculinist structure, resulting in the intense criticisms levelled at hegemonic medicine by numerous feminist scholars.[47] From Aristotle's ancient pronouncement that women were mere receptacles for male seed to Victorian treatments for hysteria, the medicalization of childbirth and the more contemporary involvement of medicine in the forced sterilization of certain groups of women,[48] "woman" signifies the pathologized object of medical epistemology, marking the female body (again) as incomplete, inferior, abject in relation to the "model man." Taking this logic to its inevitable but troubling conclusion, I have argued elsewhere that "woman," then, is also associated with death in this epistemological framework, both the antithesis of "health" and the paradoxical source of modern pathological medicine.[49] Yet, in a strange turn, this denigration also positions women as “the privileged target of disciplinary practices”[50]: where “model man” is the discursive sign of “health,” “woman” becomes his necessary pathologized foil and a particularized object of medical intervention.[51]

The clinic is the central site of this disciplinary attention. Foucault initially identifies the “clinic” as a moment of exchange—a “meeting place”—between the doctor and the patient, a spatialization enabled by the convergence of the clinical gaze with the verbalization of symptoms.[52] Within this exchange, the gaze becomes “a hearing gaze and a speaking gaze,”[53] but also a gaze deeply clouded by epistemological myths. It is, for Foucault, a precursory gaze, preceding the anatomo-clinical gaze that eventually enabled the full development of modern medical epistemology. In the nineteenth century, the secrets of disease were ultimately to be revealed in the depths of the dead body, and the mysteries of the living were exposed by a pathological knowledge of the dead. More precisely, “it is when death became the concrete a priori of medical experience that death could detach itself from counter-nature and become *embodied* in the *living bodies* of individuals.”[54]

Glimpses of the earlier clinical gaze remain in the simple exchange of the clinical moment, and in the authority with which it is imbued. For the all-knowing physician—a subject *himself* produced by the epistemological framework of medical logic—“the clinical gaze . . . burns things to their furthest truth . . . . [such that] the clinic no longer has simply to read the visible; it has to discover its secrets.”[55] Dispensing with intellectualism, “it is a gaze of concrete sensibility, a gaze that travels from body to body, and whose trajectory is situated in the space of sensible manifestation. For the clinic, all truth is sensible truth, ‘theory falls silent or almost always vanishes at the patient’s bedside . . .’”[56]

In the perfecting of this sensory skill and its advancement toward anatomo-clinical knowledge, the "tangible space of the body" is opened up no longer simply to the gaze, but to the refined and practiced "glance" of the physician.[57] This glance, Foucault explains,

> strikes at one point, which is central or decisive . . . the glance goes straight to its object . . . . The glance goes beyond what it sees; it is not misled by the immediate forms of the sensible, for it knows how to traverse them; it is essentially demystifying . . . . The glance is silent, like a finger pointing, denouncing. There is no statement in this denunciation. The glance is of the non-verbal order of *contact*, a purely ideal contact perhaps, but in fact a more *striking* contact, since it traverses more easily, and goes further beneath things. The clinical eye discovers a kinship with a new sense that prescribes its norm and epistemological structure; this is no longer the ear straining to catch a language, but the index finger palpating the depths.[58]

As Foucault summarizes, "clinical experience…was soon taken as a simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort of contact prior to all discourse, free of the burdens of language, by which two living individuals are 'trapped' in a common, but non-reciprocal situation."[59] With this transmutation of the gaze, the verbalization of symptoms fell silent, marking for once the clinical moment as a site of power/knowledge. Thus, this glance translates subject to object, individual to patient, and the temporality of the clinical moment into the regulatory spatialization of modern medicine, which expands the "non-reciprocity" of this clinical exchange beyond its production of the body as medical object and into the productive regulation of the social body.

Several aspects of this clinical moment are crucial to my discussion of the postmodern cultural clinic. First, the non-reciprocity of this clinical exchange mirrors the imbalanced vision of the Panopticon. Most obviously, the physician stands in for the guard; and the potential for disease and subsequent medical examination induce a persistent disciplinary impetus toward "health," an impetus itself closely entangled with panoptic disciplinary normalization. Taking this further, the non-reciprocity of the clinical moment implies uni-directional power—*from* the doctor, as the subject imbued with medical authority, *to* the patient/object of medical intervention. The physician embodies the authority of the medical gaze by which the process of pathologization is enacted. And, just as the panoptic gaze of disciplinary normalization subjects women more fervently than it does men, this medical gaze regulates women's bodies more stringently as well.

The binary hierarchy of normal/pathological establishes the terms by which these non-reciprocal exchanges become instances of power/knowledge production. The "physician" is subjectified as a site of power; the patient is objectified as an "ill" body in need of medical intervention or a "healthy" individual encouraged to continue with his regimes. In conventional use, this hierarchy implies an exclusive, oppositional relationship: one cannot be healthy if one is ill. However, each term (or state, or diagnosis, or subjection) informs the other, relying on its opposite for its own meaning. In a 1975 lecture at the Collège de France, Foucault makes a crucial distinction on this point. Drawing on Georges Canguilhem's classic text *The Normal and the Pathological*,[60] Foucault situates "the norm" as an exacting and coercive production within the domains in which it is utilized, such as the school, the army and, of course, the hospital.[61] Foucault suggests that, in these domains, "the norm is not simply and not even a principle of intelligibility; it is an element on the basis of which a certain exercise of power is founded and legitimized." "The norm," in other words, "brings with it a principle of both qualification and correction. The norm's function is not to exclude and reject. Rather, it is always linked to a positive technique of intervention and transformation, to a sort of normative project."[62]

Hence, the relation of "normal" and "pathological" must be reframed from its conventional interpretation: instead of positing that one cannot be healthy if one is ill, the status of both "health" and "illness" require the normalizing involvement of the physician. In the space of the clinic, the vagary of "illness" becomes the specificity of "disease," and "health" becomes the quantified measures of "normalcy" wrought under the physician's gaze.[63] Imminent in the non-reciprocal exchange of the clinical moment is the potential for either diagnosis, marking this exchange as one of intervention, transformation, correction—normalization. Pathologization is merely the mechanism by which further intervention is enabled.

The gaze alone, then, does not produce the new political anatomy of modern medicine; rather, it invokes the power/knowledge apparatus of medical epistemology which produces particularized bodies under its monitoring gaze. Therefore, the broader normative project of social medicine cannot be located simply with the individual physician. While the imbalanced face-to-face encounter in the doctor's office focuses on the curing of disease and the maintenance of health, each individual practice of the gaze potentially enables the pathological diagnosis required for normalizing interventions to continue.

But, as the normative project of medicine has been historically informed by the "great strategies of liberalism and individual contract,"[64] the particular disciplinary attention afforded to women by medicine both mediates and sustains a broader set of ideological imperatives. Thus, not only does the gaze pathologize "woman" to ensure the normalization of "model man," but it also reiterates the abjection of "woman." The non-reciprocity of the clinical moment suggests that this abjection via pathologization cannot be overcome; it is an imbalanced, one-sided exchange between an authoritative expert and a passive patient. But women's engagement with the clinic is both more complex and nebulous than this epistemological framing. On the one hand, the clinic cures; its overt and deliberate purpose is to treat the diseases that afflict the body. And, for a range of social, cultural, political and environmental reasons, women's particular roles involve them in this clinical space more frequently than men. While women live longer than men, they also tend to suffer from more chronic (though less acute) illnesses, visit the doctor more often, are hospitalized more frequently, and have higher rates of disability and mental illness than men.[65] As the caregivers of multiple generations, women also often mediate the medical care of others, often to the detriment of their own health.[66] The clinic cures women (and often, of course, does not) of yeast infections, migraine headaches, eczema and numerous other bodily indignities that code phenomonological experience as human, and also treats the illnesses of their children and the ailments of their aging parents. On the other hand, the clinic sustains the discursive spatialization of the feminized body via medical epistemology, reproducing its anomalous pathologized abjection. Despite active participation in clinical space, the imbalance of the clinical moment returns the discursive "woman" as patient to the sphere of medical control; and, her return to the clinical moment signals another opportunity for correction to the norm. In a spiral of logic, this subjection of "woman" as abject, as discursively pathologized, suggests an impossible correction, but one which instigates, nonetheless, the disciplinary role of medicine as a power/knowledge apparatus.

Along with this reiterated non-reciprocity, then, disciplinary technologies emerge as a central element of the clinic, producing specific medicalized bodies and subjects. Thomas Osborne notes, for instance, that Foucault's "notion of the clinic refers to a kind of practice or empirical orientation towards the fact of individuality."[67] The "clinic" is a method, a way of seeing, not simply an institutionalized space. The medical gaze, as the central practice of the clinic itself, produces the physician just as it surveils the patient. And, this clinical method induces regimes of individual discipline legitimized by its own self-given authority. "The domain of medicine and sickness," Osborne writes, "becomes a kind of privileged space for the coming to grips with, the labouring upon, the fabrication of, the self."[68] The clinical exchange is thus a practice that reiterates, in its non-reciprocal form, the specific political anatomy of the modern medical project. This practice, in turn, is individualized across particular bodies and subjects known only through the practice of the medical gaze.

However, as medicine has expanded further into social space, this non-reciprocity has been displaced, or at least disrupted, by the ever-increasing regimes of disciplinary normalization. As I detail in the following sections, the very terms by which medicine undertakes its normalizing project of this new political anatomy are the same terms that render this project unstable. Put another way, just as the idealized construct of the Panopticon is disrupted and manipulated by the required individualization of its potential surveillance, so too is the non-reciprocity of the clinical moment disturbed by the necessary involvement of "real" individuals with their own regimes of "health." The idealized conception of the clinical moment as a non-reciprocal exchange exposes the temporal and spatial production of the clinic, revealing the power/knowledge apparatus that informs clinical space. The normalizing project of modern medical epistemology is thereby situated in specific historical, social, political and cultural contexts. These specificities themselves produce certain spaces, bodies and identities that each require renewed negotiation of the terms of the clinical exchange. Medical authority is signified by the white coat, the stethoscope, the doctor's office, the space of the hospital, but it must be reiteratively produced through the practice of the medical gaze and the non-reciprocal exchange of the clinical moment. Though this authority now precedes and informs the face-to-face encounter of doctor and patient, its historical initiation as an exchange in time and space necessitates a messy negotiation with individual subjects who are themselves located in the power regimes of society.

Displacing the Clinical Moment

> Considered on an overall basis, the clinic appears—in terms of the doctor's experience—as a new outline of the perceptible and statable: a new distribution of the discrete elements of corporal space.
>
> Michel Foucault, *The Birth of the Clinic*[69]

In the contemporary moment, the postmodern cultural clinic emerges within the negotiations between doctor and patient, between "real" individuals and disciplinary subjects, displacing the traditional notion of "the clinic," spreading beyond its authoritative confines of walls, offices and hospitals, and into a nebulous clinical space which relies on the social expansion of medical knowledge. While the conventional notion of the clinic is that of a discrete and literal space, the postmodern cultural clinic is ever-shifting, multiplicitous and discursive. And, while the traditional clinic is about the authoritative practice of legitimized medical professionals, the postmodern cultural clinic is about the disciplinary, power-laden practices of a socially infused medical discourse. Thus, this clinic shifts and materializes into the various subjectified spaces of women's embodied practices. It is a diffuse and mutating site tied to the social practices by which it is produced, not to a particular place, disrupting traditional conceptions of medical authority and practice.

This disruption is intimately tied to the expanding authority of medicine in contemporary life, and to the non-reciprocal exchange of the clinical moment. On the one hand, the ever-expanding scope of medical authority signals the multiplication and diffusion of its utility as a biopolitical mechanism; but, the increasingly dominant role of medicine as a scientific discipline, an authority on disease, a social producer and political mediator also increases the cultural relevance of the space of "the clinic." Whether the research lab where revolutionary cancer treatments are being refined, the operating room in which the first islet transplant occurred, the boutique suites of cosmetic surgeons, or the comparatively mundane examination room of the family physician, the continuing resignification of the clinic as a discrete, though powerful, physical space elides its production through the clinical moment. On the other hand, the disciplinary impetus of medicine's normalizing project has been increasingly taken up by its patients. Entwined as it is with the panoptic gaze of disciplinary normalization, and linked with the social valuing of certain bodies, identities, practices and desires, the medical gaze has been incorporated into the lives of individuals who are themselves subject to the authoritative practice of this same gaze. The notion that the clinic is materialized into discrete spaces via the medical gaze, via the non-reciprocal exchange of the clinical moment, signals its potential materialization elsewhere, whether the bathroom mirror, the grocery store line up, the bedroom, the workplace, the psyche of the individual.

Emerging from these contradictions, the postmodern cultural clinic thus exposes the production of the medical apparatus of power/knowledge through the non-reciprocal exchange of the clinical moment; and, it reveals the mediation of this clinical moment via the medical gaze. By returning to this initial clinical moment, the spatialization of medical authority into discrete space, and into only certain spaces, is potentially disrupted. However, the authority of the medical establishment still holds hegemonic force, which in turn enhances the productive/prohibitive power of the postmodern cultural clinic.

This transmutation of the clinical moment exemplifies the confusions and contradictions of postmodernism. Patricia Waugh suggests that "postmodernism denies the possibility of an 'objective' science discovering the laws of an independently existing reality; it repudiates the pursuit of universal and rational ethical principles; it rejects the existence of a separate category of the 'aesthetic' which is removed from the realms of science, ethics or everyday practice."[70] The displacements of the postmodern cultural clinic disrupt the centralized, non-reciprocal authority of the clinical moment. In so doing, the historical residues of medical epistemology are themselves disrupted. Patient-centred care initiatives deliberately relinquish, or at least reposition, medical control over decision-making. Incorporation of the medical gaze into the practices of everyday life extends medical normalization, but also diffuses the role of the physician. Medicalized disciplinary practices themselves encapsulate access to power, which enables a disruption of the masculinized authority over the abject pathologized "woman" of medical epistemology. Participants in the pro-anorexia movement, for instance, deliberately manipulate the terms of the medical encounter and anorexic inpatients re-read medical standards of recovery against their intended use.

While precisely informed by the power/knowledge apparatus of medicine and its increasing scope of disciplinary normalization, the displacement of the clinical moment to other sites, bodies, exchanges and individuals exposes the sociocultural, politicized production of medicine. Three specific displacements of the clinical moment are particularly relevant to my discussion of the postmodern cultural clinic: its displacement into "the undifferentiated space between bodies,"[71] its displacement across cultural texts and sites, and its displacement into a space of failure. These multiple, but often contradictory, clinical displacements each rely on Foucault's initial conception of the clinical moment as a non-reciprocal exchange.

As discussed earlier, the medical gaze that emerged in the twentieth century focused not just on the individual body, but on "the undifferentiated space between bodies."[72] As David Armstrong outlines, health became linked to physical culture and social environments; "social medicine" now focused on the hygiene and deviance of social groups, seeking out standards of "normal health" that could be replicated throughout the entire population; health centres were established that would serve to educate not only medical students but, more importantly, individuals by drawing them into systems of surveillance and discipline.[73] For women, this new focus manifested itself in the eugenics movement, "well baby" clinics, the medicalization of contraception and childbirth, and the elevation of the physician to family advisor.[74] As Armstrong concludes, "the existence of such a social medicine and its various characteristics—concern with the normal and positive health, with screening and social relationships—was a manifestation of an analysable social space between bodies."[75]

In a 1976 lecture at the Collège de France, Foucault identifies such examples of social medicine as "regulatory mechanisms," functioning at the level of the "multiple body"[76]—the population—and "taking control of life and the biological processes of man-as-species and of ensuring that they are not disciplined, but regularized."[77] Foucault distinguishes such "regulatory mechanisms," which are focused on the life and death of the economic, social and political body, from "disciplinary mechanisms" which are focused on the individual body. Though these two distinct mechanisms function at different levels and with different aims, they are "not mutually exclusive and can be articulated with each other."[78] Referring to individualized disciplinary technologies, for example, Foucault writes that "disciplines in fact always tend to escape the institutional or local framework in which they are trapped"[79]; and, regulatory technologies encourage particular individualized practices, while dissuading the individual from others.[80] Medical discourse is one specific instance of this coalescence, becoming "a political intervention-technique with specific power-effects. Medicine is a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects."[81] With its particular focus on both the individual body and the social space between bodies, medicine produces particular norms "that can be applied to both a body one wishes to discipline and a population one wishes to regularize."[82]

The postmodern cultural clinic emerges in the spaces between the disciplinary technologies of the individual and the regulatory technologies of the social body, the spaces in which "the norm" circulates.[83] The biopower of normalization is translated to individualized bodies, practices and locations. In the contemporary moment, however, this circulation of the norm evokes multiple sites of regulation, multiple bodily forms, multiple displacements of the medical gaze. It materializes in the translation of the non-reciprocal exchange of the clinical moment to ever-increasing sites of medical surveillance, to an ever-expanding set of social "problems," to the next new clinical mechanism of diagnosis and treatment. Medicine's normalizing force has expanded beyond the discrete face-to-face exchange between doctor and patient to increasingly intimate bodily sites, as well as to the non-embodied sites of the social body. The impetus of the clinical moment now extends beyond bodies and into machines: simplistic x-rays have given way to MRIs, CT scans, video diagnosis and treatment, and emergent nano-technologies in which the practice of the medical gaze itself is displaced (or perhaps mediated) by technologies that visualize the body. It emerges in the everyday practices of the individual: drug regimes, fish oils, vitamins, diets and exercise preclude the normalizing authority of the doctor's gaze. This impetus insidiously invades everyday space, as the recent explosion of health and lifestyle magazines at the grocery store checkout attest. And, it erupts in legislative debates about "fat" taxes and government concerns about the obesity epidemic.[84] Each displaced manifestation of the clinical moment invokes the threat of medical intervention and, thus, expands the normalizing project of modern medical epistemology.

Second, and relatedly, the clinical moment is also displaced across cultural texts and sites to those beyond a conventional understanding of medical space. To examine these forms of displacement, I want to examine briefly two different but related perspectives on the clinic: Donna Haraway's dismissal of the clinic, and Chatterji, Chattoo and Das's re-examination of the clinic in relation to aging bodies. In her classic text, "A Manifesto for Cyborgs," Haraway declares that "it is time to write *The Death of the Clinic*. The clinic's methods required bodies and works; we have texts and surfaces. Our dominations don't work by medicalization and normalization any more; they work by networking, communications redesign, stress management. Normalization gives way to automation, utter redundancy."[85] In their work on aging bodies, Chatterji, Chattoo and Das take up Haraway's call to refigure the clinic, but suggest that her utopic dismissal of the clinic, along with her sharp distinctions "between birth and death, clinical practice and inscription, organism and biotic component," ignores the contemporary significance of the clinic as both an idea and a practice.[86] I would add that Haraway's interpretation of the clinic is too literal, as well. Chatterji, Chattoo and Das argue, instead, that "there are intricate relations between inscriptions, documents, bodies and work which make a narrative of complete transition from earlier to new forms of biomedical power difficult to maintain. Some of these relations are reconfiguring the clinic in new ways—in other cases medicalisation and normalisation are actualised on bodies that cannot be recrafted through information or biotechnology."[87]

Despite their differences, both of these arguments are relevant to my discussion of the postmodern cultural clinic. Haraway demands a disruption of the non-reciprocal action of the medical gaze upon passive bodies and a rejection of the declarations that enact the normalizing impetus of medical practice. But, between Haraway's "texts and surfaces" are the bodies and works of medicalization that she seeks to disavow. Chatterji, Chattoo and Das rightly suggest that "intricate relations" now render the clinic as a multiplicitous entity; where one form of biomedical power fails to achieve its regulatory effect, other forms take over. The medical gaze is diffused, then, across bodies, works, texts and surfaces, multiplying the clinical moment while displacing its intended purpose.

The sensory field of this transmuted clinical moment is not only the individual body but, rather, a field of bodies. It takes in a culture of images and regimes, bodies and works, texts and surfaces, all sites materialized through the invocation of the medical gaze. I address the incorporation of the medical gaze into individual identity further below. For now, it is important to note that the refined and productive glance of the physician has been displaced through this diffusion of clinical space. The physician's glance is now embodied in the individuals upon which its hegemonic use is still applied. Just as the physician is carefully trained to wield this diagnostic mechanism, individuals now perpetually practice the medical gaze. The displacement of this pathologizing practice reiterates the non-reciprocal exchange of the clinical moment into the everyday lives of individuals, ensuring the individual disciplinary technologies required to maintain the social standards of "health."

Finally, what is revealed in these various displacements is that the postmodern cultural clinic is not a geography of place. It is a geography of bodies and embodied practices, spanning across individual women's struggles with embodiment; its representations—textual, embodied, discursive and otherwise—shift as these struggles themselves shift with the particularities of cultural milieux. Its geography is one of multiple sites reiteratively produced, viewed, inhabited and compared: Alesse® advertisements posted in the women's washroom[88]; the airbrushed breasts of the supermodel viewed against the asymmetrical breasts in the bedroom mirror; Kate Winslet's unauthorized digitized thighs[89] read against all too embodied cellulite; the BMI chart calling out from the wall of the doctor's office.

In each reading of these cultural texts, a denigration of feminized spatialization is at work that reiterates discursive feminized pathologization across particular moments in time and particular disciplinary practices. Each text invokes disciplinary failure. Each disciplinary failure incorporates failure itself into the always inadequate subjectification of feminized identity. Women's embodied identities do not pre-exist these fraught moments. Rather, each reading of a cultural text and each disciplinary failure spatializes feminized identity *as* failure. Alesse® reiterates the need to control the unruly female body, both the individual woman's body on a monthly basis and the collective body of "woman." The airbrushed breasts of the supermodel prescribe an optimal, and impossible, embodiment of mammary glands. Kate Winslet, herself displaced by technological interventions, signifies the displacement of flesh required to normalize each woman's excess. And, along with the ever-present scale, the heart attack risk assessment chart, the due date calculator and the HIV screening protocols, the BMI chart quantifies the need to standardize the female body, linking each woman's disciplinary struggles back to the collective of female bodies subject to the regulation of the medical gaze. Such cultural prescriptions again invoke the confusions of feminine identity and the perpetual failures of its disciplinary practices, drawing women back, again and again, to the normalizing project of modern medical epistemology.

Incorporating the Medical Gaze

> Every great thought in the field of pathology lays down a configuration for disease whose spatial requisites are not necessarily those of classical geometry . . . . The space of *configuration* of the disease and the space of *localization* of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time—the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze, since in the same perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible lesions of the organism and the coherence of pathological forms; the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The "glance" has simply to exercise its right to origin over the truth.
>
> Michel Foucault, *The Birth of the Clinic*[90]

As the productive mediator of the non-reciprocal exchange of the clinical moment, the medical gaze enables subversive potential. Despite its productive practice, it was tied historically to an absolutist vision of knowledge: what could be seen and what could be spoken of the body[91] prompted an idealization of this emerging practice. Yet, when this gaze is manifested in contemporary everyday life, it is transmuted beyond its restricted use in an idealized realm of medicine. If the medical gaze is inextricably linked to speech, though, as its verbalization of disease is a hallmark of modern medical epistemology, the gaze of the postmodern cultural clinic is imbued with the unstable contemporary languages of culture and social life, of hierarchies and hegemonies, and of a multiplicity of gazes, each turning in on itself, each reproducing another clinical space. It folds back upon its own logic, neither clear nor linear, and isolated to neither the all-knowing physician nor the literal space of the clinic. Like the cultural clinic of which it is a part, this pathologizing gaze is multi-faceted, often unacknowledged and latent.

Emerging into the realms of popular culture, the medical gaze of the postmodern cultural clinic is inextricably entwined with multiple gazes that manifest particular social hegemonies, as well as being wielded by multiple subjects. Certain cultural contexts produce particular visual forms that enable this multiplicitous gaze, reflecting their specific milieux, media and textualizations. Oprah Winfrey's televisual clinic, for example, employs the displacements of the televisual lens and the voyeuristic gaze to particular effect. But, I believe several consistent visual themes are employed across these different contexts, enabling the expansion of medical epistemology into ever-increasing cultural sites. First, as outlined earlier, Foucault has demonstrated how the punitive panoptic gaze of disciplinary normalization has embedded itself into the identities of individuals, prompting their self-discipline to various social standards and their engagement with social disciplinary regimes. And, many authors have demonstrated how this particular gaze surveils women more fervently than it does men. With this gaze already incorporated into feminized identity, an expanded and diffused medical gaze entwines itself with women's self-disciplinary practices. Medicine extends this disciplinary engagement both through women's everyday experiences with the clinic and via the discursive pathologized abjection of "woman." Thus, feminized disciplinary normalization is imbued with the punitive and regulatory authority of the medical gaze, which is itself enhanced by the "faceless gaze" of society.

The voyeuristic patriarchal gaze of modern cinema, identified by Laura Mulvey, is also at play in the postmodern cultural clinic. As Mulvey points out, the fetishistic scopophilia invoked by cinematic narratives perpetuates the oppositional hierarchy of woman as the passive "gazed upon" figure and man as the active gazer. This motif reflects hegemonic cultural narratives via the gaze, reproducing the imbalances of the gender binary hierarchy. This gaze thus expands phallocentrism into everyday cultural spaces.[92]

I draw another facet of this altered medical gaze from Norman K. Denzin's discussion of the cinematic gaze, in which he extends and modifies Mulvey's earlier articulation of the voyeuristic gaze.[93] Denzin argues that the cinematic gaze is now a distinctly postmodern gaze interiorized by the individual, by which the public/private dialectic becomes intimately entwined with the technologies of gender and the multiple gazes of twentieth century life: the camera's gaze; the reflective, narrative gaze; the everyday gaze; the spectorial gaze; the new urban gaze; the voyeur's gaze. Denzin positions this gaze as central to Foucault's disciplinary society. As a productive/prohibitive mechanism of social regulation, it displaces the individual eye, thereby displacing other systems of knowledge into the space of individual experience. This postmodern, interiorized cinematic gaze thus becomes visually hegemonic. Denzin wishes "to expose the cultural logics which have led the postmodern self to interiorize this investigative gaze. This investigative gaze is more than a gaze; it is the exercise of power in its rawest, yet most sophisticated forms. This gaze unmasks all of us, and makes each of us a willing participant in the regimes of surveillance, power and control that threaten to destroy the very fabrics of postmodern life."[94]

Following Denzin's logic, the medical gaze, as it is manifested in the postmodern cultural clinic, is informed by other power/knowledge apparatuses, infused with their productive/prohibitive force and entwined with their particular disciplinary gazes. As such, its practice invokes multiplicitous disciplinary practices, thereby producing the complex and often contradictory bodily subjectivities willed by these multiple constraints—those of normative femininity, racialization, heteronormativity, and middle-class hegemonies. In turn, this medical gaze applies its logic of and authority over pathologization to the social hegemonies with which it is entwined. The postmodern cultural clinic materializes through this now multiplicitous gaze in which the multiple subordinations of women's embodied subjectivities converge.

I would also amend Denzin's analysis to suggest that the multiplicitous gaze of the postmodern cultural clinic is incorporated, not interiorized, into the psyche of the "postmodern self." I use the term "incorporation" rather than "interiorization," or even "inscription," because, first, interiorization implies an explicit division of interior and exterior across which the medical gaze must pass. It constructs the body in a familiar, though inaccurate, dualistic manner, separating the processes and productions of embodiment into two discursive fields. Similarly, inscription suggests an impenetrable surface that shields an internal or underlying body from discursive effect, again invoking divided bodies and split subjectivities. In these ways, both terms also suggest the existence of a "pre-discursive" body that is beyond or prior to the disciplinary practices which bring it into being. This long-standing perspective objectifies the body away from its embodied production and away from the embodied subject. Neither separations are possible, however, if the discourses that subjectify the individual cannot be escaped. Yet, each of these senses of the body have a tenacious presence in cultural discourse, constituting the body at once as a reified object and as an unruly (often feminized) prison. They suggest that, if appropriately acted upon, this body will be brought under control.

Judith Butler interrogates this slippage in her analysis of bodily inscriptions, and of Foucault's construction of the body in particular. While her critique is wide-ranging, I want to highlight several points that are relevant to my discussion of the incorporation of the medical gaze. First, Butler contests Foucault's figuring of "the body [as] the inscribed surface of events," as it and similar perspectives constitute the body through Christian and Cartesian discourses that reinscribe an inert body within the structuralist framework of mind/body, culture/nature, active/passive.[95] Such discourses interpret gendered identity as stemming from the stability of a fixed, usually sexed, body. However, Butler argues that the distinction between "inner" and "outer," upon which this logic relies, makes "sense only with reference to a mediating boundary that strives for stability," constituting "a binary distinction that stabilizes and consolidates the coherent subject."[96] Yet, if the body constitutes the internal core or innate substance of the subject, gendered identity would not be constrained to only two hegemonic forms, nor would it require performative resignification to produce its phantasmatic stability. That gender does rely on reiterated performativity, and not a fixed biological or even psychic core, disrupts the notion of a pre-discursive body.[97] According to Butler, any concrete distinction between inner and outer psychic space is thus specious.[98] The body is conventionally understood to contain the true "essence" of the individual, but this understanding itself constructs an imaginary interior from which this "truth" emerges. But, as Butler contends, for individuals subject to disciplinary regimes (and, here she speaks specifically of Foucault's prisoners), their bodies are "compelled to signify the prohibitive law as their very essence, style, and necessity. That law is not literally internalized, but *incorporated*, with the consequence that bodies are produced which signify that law on and through the body; there the law is manifest as the essence of their selves, the meaning of their soul, their conscience, the law of their desire. In effect, the law is at once fully manifest and fully latent, for it never appears as external to the bodies it subjects and subjectivates."[99]

Thus, I suggest that the multiplicitous gaze of the postmodern cultural clinic is incorporated into feminized identity, as a practice—a performance—that reiterates the imbalances of the non-reciprocal exchange of the clinical moment. It reproduces the punitive binaries of medical epistemology via the disciplinary practices of the individual. Honed over years of experience, it also becomes the refined and practiced "glance." This glance, now multiplicitously constituted, focuses the complexities of regulatory regimes into a single moment, repeated with each glance in the mirror, tug of the jeans, meal prepared or passed over. David Armstrong calls such entrenched incorporation the "perpetual gaze," which is most successfully achieved through the surveillance and regulation of the individual from childhood[100]; Foucault refers to it as the production of "permanent surveillance."[101] This reiterative performance of the gaze itself re-invokes the notion of the objectified body. In a displacement of bodies and identities, the individual practicing this gaze objectifies her own body; in this moment, her body is coded as the silent, observed body of the clinical exchange. Through this entire process, the non-reciprocity of the clinical moment, which discursively produces feminized pathologized abjection, emerges into everyday space. The basic premise of pathologization, skewed into epistemologies of feminine aesthetics, discipline and popular culture, erupts into this displaced clinical site, signified by the embodied (yet objectified) individual.

On an individual level, this incorporation is reiterated through women's embodied practices—their performances of feminized identity. Women's self-disciplinary practices find renewed force in the convergence of the productive ideals of normative femininity with the punitive force of medical pathologization, as well as in the voyeuristic and cinematic gaze now insidiously entrenched in postmodern life. This altered gaze sharpens the punitive impetus of women's practices by fusing them with the legitimized authority of medical knowledge; it expands the disciplinary gaze of normative femininity and amplifies the pathologizing gaze of the clinical moment. When these multiple productive and disciplinary gazes come together, the idealized body which is constitutive of normative femininity—the thin feminine ideal—becomes a marker by which women are pathologized. Not only do women have to look and behave in certain ways, they now have to do so in order to maintain their "health." This medicalization of women's self-disciplinary efforts catapults them into a new space of discursive and disciplinary failure—to be more precise, the multiplicitous spaces of the postmodern cultural clinic.

Spatializing Normative Femininity

> Discipline is a political anatomy of detail.
>
> Michel Foucault, *Discipline & Punish*[102]

Through the displacement of the clinical moment and the incorporation of the medical gaze, the disciplinary impetus of medical authority is spatialized into popular culture and everyday space, across bodies and texts, into the practices of normative femininity and the psyche of the individual woman. While each woman reiterates and extends this impetus with her own disciplinary practices, this spatialization is not isolated to a singular site or identity. Instead, it materializes with each "healthy" choice, each frustrated moment in front of the mirror, each remembrance of the doctor's warnings about fat content, exercise, blood pressure and diabetes. It bleeds into each twinge of bodily dissatisfaction. Each feminized disciplinary practice spatializes the postmodern cultural clinic.

In these spatializations, the disciplinary regimes of health and beauty converge. On the one hand, the cult of thinness maps onto our cultural ideals of health. The thin, fit body is constructed as the ideal by which health can be measured: BMIs, body weights and waist circumferences quantify disciplinary success or failure. Yet, women involved with anorexic or bulimic practices would not necessarily be exemplars of "good health," nor would thin elderly women who are at risk of osteoporosis, although both may appear to be healthy by standard measures. On the other hand, the hegemonic demand that women should take up less space with their needs, wants, bodies and desires is reinforced by the "objective" language of medical science and re-articulated as medical concern over obesity. Culturally, "fat" signifies laziness, dirtiness and, most recently, lack of attention to one's health. For women, it also veers into more dangerous territory: fat women are not attractive (at least, not conventionally).[103] Fat signifies too much space, too little discipline, and individual failure to control the unruly female body.

The paradox of this social construction of obesity is that, in North America at least, obesity is the norm,[104] but thinness is idealized as "normal." Against the continued cultural idealization of the thin body, obesity is stigmatized in popular culture as "ugly" and by medicine as unhealthy. Almost daily, it seems, a new study is released on the negative health impacts of obesity, adding scientific weight to the cultural derision toward fatness. This paradox is especially relevant for women. Numerous theories explore why thinness has been increasingly valorized and associated with feminine identity over the last century.[105] Feminist scholars, in particular, connect this association with the patriarchal denigration of women, reducing women, again, to their bodies and diminishing those bodies that then remain.[106] As women expand their rights and move beyond traditional gender roles in modernity, the social control rendered through their bodies increases in retaliation.[107] As many scholars have now illustrated, today the incorporation of this denigration most plagues women, who turn social control on themselves through the punitive production of their own disciplinary practices.[108] It should be no surprise then that, as study after study shows, North American women are overwhelmingly dissatisfied with their bodies, and the majority of them are dieting at any given time.[109] Despite calls to abandon the bathroom scale, the advocacy of the "fat acceptance" movement and the shift from "weight loss" to "healthy eating," being overweight is still stigmatized and disproportionately so for women.

This is not to say that women's health issues are not important; recent decades have seen changes in medicine and medical practices that have benefited women. Rather, I am suggesting that the particular collision of medicine and beauty needs to be problematized in context of the postmodern cultural clinic. When this context is examined from a critical feminist perspective, paradoxes and contradictions arise that expose the power-laden discourses embedded in cultural constructions of health and beauty.

For instance, women are not simply duped into desiring the thin aesthetic. The convergence of medicine and beauty invokes more conflicted and complicated engagements with the disciplinary practices of normative femininity. And, it would over-simplify these engagements to say that women are constrained and unable to break the bonds of patriarchy. Old notions of the passive, docile woman no longer ring true. Many women find them laughable, and the post-feminist move away from hard-core, second wave feminist values suggests that women no longer see the "struggle" in the same way. Indeed, contemporary femininity often seems to refute the traditional construction of the "feminine" as passive. Many (though not all) women's lives have changed significantly over the past century, and their "active" lives are increasingly acknowledged. While women experience the constraints of sexism and heterosexism in subtle and not so subtle ways, some now enjoy choices and opportunities not available to women of earlier generations (and, still not available to women of certain locations, nationalities and social groups), albeit often constrained choices and limited opportunities, and often choices afforded by their privileged social, political and cultural locations. And, some benefit from the struggles of earlier generations of women who knew very different lives.

Within contemporary women's struggles to balance the multiple demands of their busy lives, normative femininity is nonetheless actively produced. On one level, the resilience of normative femininity as a disciplinary regime comes from its reiterative hegemonic production. Expressions of femininity vary within and across cultures, generations, social groups, locations, and individual women's lives. Context-specific codings of the feminine aesthetic are different in rural Alberta and central London, but its productive force remains relevant and pressing. This hegemonic elasticity enables variation; and, this variation construes the hegemonic force of femininity as absent. Women have "choice": they are not necessarily constrained in the ways their mothers were.

Yet, the thin aesthetic is still marked by "whiteness," affluence and hetero-desire, exposing it as a hegemonic apparatus of power/knowledge. It prompts and measures women's successes not just by body size, but also by ability, heternormativity, class, nation, religion, colour. As discussed earlier, "western" norms of female body size and shape are now entrenched in the globalization of what is typically seen as an "American" ethos, inculcating diverse cultures and groups of women to its narrow standards of appropriate feminized embodiment. And, as marginalized women take up the constraining practices of disciplinary femininity to mediate their oppressions and traumas, these practices are no longer confined to "privileged" groups of women. This diversity signals an expansion of the thin feminine aesthetic, both in its appeal and its regulatory force.

Disruptive expressions of femininity so often become clear only when they occur and are judged as unacceptable. Less troubling variations from the norm are more murkily disdained, but still prompt social sanctions. Small punitive judgments from co-workers, friends and family are just as power-laden as loud public outcries against "truly distasteful" expressions of femininity. Yet, while no one can achieve the ideal, some women seem to "measure up" more easily than others, accessing certain membership to the "in-groups" of social acceptability on the basis of punitive social hierarchies and discriminations. Still, all women are subject to judgment against the thin ideal, pushing their disciplinary efforts ever further and inevitably failing in this pursuit.

"Discipline is a political anatomy of detail,"[110] Foucault asserts. Hence, the minutiae of weight loss regimes, the detail of pro-anorexia websites and the routinization of anorexic inpatient treatment protocols reveal much about the "discipline" of the unruly female body. Joan Jacobs Brumberg, for one, argues that women's embodied disciplinary practices signal the modern necessity for internal controls over the female body, constituting identity as malleable via the body[111]: the body is proxy for the self.[112] Such "body projects," therefore, mark unaltered feminine identity and unchanged female bodies as incomplete, inferior and abnormal. Yet, these projects are never-ending, as feminine aesthetic ideals both change and are unattainable in any form. Hence, the feminized self-discipline required for an appropriate body-subject are increasingly invasive, increasingly focused on particular body parts, and central to feminized identity at increasingly younger ages.[113] The political anatomy of the female body is never complete.

Across this ever-failing anatomy, the thin feminine aesthetic still holds substantial cultural weight. Seemingly regardless of context, women are disciplining their bodies in order to demonstrate their personal worth. That this discipline is now reinforced by the normalizing project of medical epistemology heightens its punitive impetus. At the same time, however, this regularizing mechanism is discursively absented by its operation through women's practices of the incorporated medical gaze. Individual women are responsible for disciplining their bodies, as well as for the inevitable failure to meet the impossible ideals that perpetuate their practices. It seems that feminized passivity has given way to pathologization, and pathologization has given way to individual failure. It is no longer the fate of women to be seen as the frail, delicate creatures of the Victorian era, although women are still haunted by remnants of this discourse. And, as medicine's institutionalized role as paternal manager of women slowly slips from view, a muted and mutated variation of its social control is emerging, embedded in women's empowered choices over their own lives and in their embodied disciplinary practices.

Now infused with the rhetoric of health, the thin feminine ideal is resistant to dismissal on the grounds that it is purely aesthetic. Norms of beauty are muddled with signs of health, adding to the resiliency of normative femininity as a disciplinary regime: thinness signifies beauty, health and an appropriately maintained (i.e., controlled) body, all of which signify the individual woman as "good." Attention to the ever-increasing regimes of "good health" is also inextricably entwined with the regulation of an entire population, producing not only healthy individuals but also a healthy social body. The postmodern cultural clinic serves this broader regulatory mechanism by operating through both the regimes of health and the guise of beauty. This convergence extends the regulatory success of both apparatuses. If one disciplinary impetus fails, the other will take over, ensuring the continuation of normative femininity as an apparatus of power/knowledge. Whether for health or vanity, this collusion of medicine and beauty re/forms the thin feminine aesthetic as integral to the well-being and identity of the individual, one practice and body at a time.

Throughout these spatializations of normative femininity, the body remains stubborn in its materiality. Cultural discourse still suggests that if the body can be overcome, the social rewards of health and beauty can be attained. Thus, despite women's embodied and empowered choices, their struggles with the unruly female body continue. Susan Bordo suggests that this body signifies on two registers.[114] At the level of the social, the unruly and objectified body signifies inevitable failure. At the individual level, it signals women's failure to control *themselves*. This slippery signification, in turn, instigates a constant, troubled negotiation between feminized identity, discipline and embodiment.

The case studies in the following chapters illustrate how this negotiation erupts into the everyday spaces of popular culture and the embodied spaces of women's lives. The medical protocols for anorexic inpatient treatment solidify this negotiation into a measure of recovery weight, to be achieved through strict adherence to treatment regimes. In Oprah Winfrey's weight loss discourse, "mindfulness" is the code word for successfully negotiating this conundrum: fill the mind with disciplinary mantras to vacate the over-powering body, thereby empowering the individual woman to reveal the "true self" buried under all of her fat. The pro-anorexia movement dispenses entirely with the fallacy of overcoming the body, however, by exposing the feminized struggle with embodiment as endless and by taking up this constant struggle as its sole focus. No single displacement of the clinical moment, though, signifies this unending negotiation in its entirety. Each time a woman looks in the mirror, a cultural text reiterates the normalizing impetus of modern medicine, or a social site invokes the productive/prohibitive force of the medical gaze, women are drawn into the disciplinary regimes of the postmodern cultural clinic.

Notes

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[1] Polivy and Herman, “Diagnosis and Treatment of Normal Eating.” See also the “Pro-Anorexia” chapter, notes 112-115.

[2] Statistics Canada research suggests, for instance, that nearly one-quarter (23.1%) of adult Canadians are obese and an additional 36.1 percent are overweight. While Canada’s rate of adult obesity is lower than American obesity figures in all categories of analysis, nearly two-thirds of Canadian adults are either overweight or obese, making excess weight the norm for Canadian adults. While Canadian men and women are equally likely to be obese, a higher proportion of women are in the most severe classification of obesity. See Statistics Canada, “Nutrition”; and, Tjepkema, “Adult Obesity.”

[3] Many studies now suggest that body dissatisfaction is increasing among young and adolescent girls: they fear becoming fat, are dieting at increasingly younger ages and increasingly participate in dangerous dieting behaviours. While boys also struggle with these issues, this trend appears to be disproportionately experienced by girls. See, for example, Edmunds and Hill, “Dieting and the Family Context”; Ikeda, “Dieting Among Children”; Jones et al., “Disordered Eating Attitudes”; McVey, Tweed and Blackmore, “Dieting Among Preadolescent”; Neumark-Sztainer et al., “Lessons Learned about Adolescent Nutrition”; Packard and Krogstrand, “Half of Rural Girls”; Schur, Sanders and Steiner, “Body Dissatisfaction”; Shapiro, Newcomb and Loeb, “Fear of Fat”; and, Stein and Reichert, “Extreme Eating Behaviors.”

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[4] Foucault, *Birth of the Clinic*, 110-111.

[5] Foucault, *Power/Knowledge*; and, Foucault, *Discipline*.

[6] Foucault, *Power*, 283.

[7] Ibid., 137.

[8] Ibid.

[9] In a large body of literature, see for example, Bordo, *Unbearable Weight*; Brown and Jasper, *Consuming Passions*; Chernin, *The Hungry Self*; Chernin, *The Obsession*; Edut, *Body Outlaws*; Fallon, Katzman and Wooley, *Feminist Perspectives on Eating Disorders*; Gremillion, *Feeding Anorexia*; Hepworth, *The Social Construction of Anorexia Nervosa*; Malson, *The Thin Woman*; Nasser, *Culture and Weight Consciousness*; Orbach, *Fat is a Feminist Issue*; and, Thompson, *A Hunger So Wide*.

[10] Bartky, "Modernization of Patriarchal Power."

[11] Armstrong, *Political Anatomy*, 6.

[12] In *The Birth of the Clinic* and other texts, Foucault refers to the medical gaze in various ways: the clinical gaze is that which emerged early in the transitioning to modern medical epistemology; the glance is the refined practice of the clinical gaze; and, the anatomo-clinical gaze reflects the nineteenth century turn toward pathological anatomy as the ultimate source of knowledge of disease and the body. When I refer to Foucault's specific uses of the gaze, I use the specific term he employs. Otherwise, I refer to this mechanism of medical epistemology as "the medical gaze."

[13] Foucault, *Discipline*, 205.

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[14] Ibid., 209.

[15] Ibid., 205.

[16] Ibid., 208.

[17] Ibid., 224.

[18] Ibid., 139.

[19] Ibid., 227.

[20] Ibid., 138.

[21] Ibid.

[22] Bartky, "Modernization of Patriarchal Power," 78.

[23] Ibid., 73-74.

[24] Dworkin, "Gynocide."

[25] Haber, "Foucault Pumped."

[26] Bordo, *Unbearable Weight.*

[27] Chernin, *Obsession.*

[28] See note 9 above.

[29] See, for example, Edut, *Body Outlaws*; hooks, "Selling Hot Pussy"; Hurtado, "Relating to Privilege"; Ikemoto, "Code of Perfect Pregnancy"; Nasser, *Culture and Weight Consciousness*; Thompson, *A Hunger so Wide*; and, Weitz, *Politics of Women's Bodies.*

[30] Nasser, *Culture and Weight Consciousness*, 46.

[31] Thompson, *A Hunger so Wide.*

[32] Many feminist theorists, therapists and researchers note this productive contraction. For detailed discussion, see Bordo, *Unbearable Weight*; Bordo,

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"Feminism, Foucault, and the Politics of the Body"; Butler, *Gender Trouble*; Butler, *Bodies That Matter*; Chernin, *Obsession*; Davis, "My Body is my Art"; Edut, *Body Outlaws*; Gilligan, "Joining the Resistance"; Gremillion, *Feeding Anorexia*; Haber, "Foucault Pumped"; Morgan, "Women and the Knife"; Sawicki, "Feminism, Foucault, and 'Subjects' of Power and Freedom"; and, Weitz, "Women and their Hair."

[33] See, for instance, Bordo, *Unbearable Weight*; Chernin, *Obsession*; and, Haber, "Foucault Pumped".

[34] Barkty, "Modernization of Patriarchal Power," 80 (emphases in original).

[35] Foucault, *History of Sexuality*, esp. 103-114.

[36] Armstrong, *Political Anatomy*, 5.

[37] Ibid., 6.

[38] Ibid.

[39] Ibid.

[40] Ibid.

[41] David Armstrong, "The Patient's View," *Social Science and Medicine* 18, no. 9 (1984): 739, as paraphrased in Lupton, *Medicine as Culture*, 91.

[42] Foucault, *Birth of the Clinic*, esp. 34-36.

[43] See, for example, Anderson, *Cultivation of Whiteness*; Ernst and Harris, *Race, Science and Medicine*; Kelm, *Colonizing Bodies*; Kuntz, *Deadly Medicine*; Schiebinger, "Theories of Gender and Race"; MacLeod and Lewis, *Disease, Medicine and Empire*; Price and Shildrick, "Mapping the Colonial Body"; Schwartz, *Birthing a Slave*; and, Weindling, *Health, Race, and German Politics*.

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[44] Foucault, *Birth of the Clinic*, 34 (emphasis in original).

[45] See, for example, Bell, "Reluctantly Finding Woman as Death"; Jordanova, "Natural Facts"; Jordanova, *Nature Displayed*; Lupton, *Medicine as Culture*; Shildrick, *Leaky Bodies*; and, Turner, *Medical Power*.

[46] Foucault, *Birth of the Clinic*, 34.

[47] See, for example, Laurence and Weinhouse, *Outrageous Practices*; Lorber and Moore, *Gender and the Social Construction of Illness*; Lupton, *Medicine as Culture*; Oakley, *Essays on Women, Medicine and Health*; Scambler, "Gender, Health and Feminist Debate"; and, Wilkinson and Kitzinger, *Women and Health.*

[48] In a large body of literature, see for example, Archimedes, *Gendered Pathologies*; Bashford, *Purity and Pollution*; Brodie, *Contraception and Abortion*; Comacchio, "Motherhood in Crisis"; Dowbiggin, *Keeping America Sane*; Ehrenreich and English, *Witches, Midwives and Nurses*; Feldberg, *Women, Health and Nation*; Ikemoto, "Code of Perfect Pregnancy"; King, *Hippocrates' Woman*; Oakley, *Captured Womb*; Reagan, *When Abortion was a Crime*; Reissman, "Women and Medicalization"; Shildrick, *Leaky Bodies*; and, *Sterilization of Leilani Muir*.

[49] See Bell, "Reluctantly Finding Woman-As-Death."

[50] Shildrick, *Leaky Bodies*, 50. While Shildrick is specifically referring to the treatment of disabled women, she also states that "state-defined disability mirrors the phenomenological experience of women generally . . . . It is worth noting too that in so far as disability/non-disability is positioned as a quasi-structural binary it impacts on the standards of normalcy operative for femininity itself. The

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insertion of female bodies into systems of normalisation, and the emergence of variable and hierarchical constructs of feminine identity, are highly mediated by such considerations."

[51] Even early experimental x-rays used women as their objects of study—first, a woman's hand and, later, a dead fetus entombed in a living womb. See Kevles, *Naked to the Bone*, 20 and 230 respectively.

[52] Foucault, *Birth of the Clinic*, 110-111.

[53] Ibid., 115.

[54] Ibid., 196 (emphasis in original).

[55] Ibid., 120.

[56] Ibid., 120, citing Corvisart.

[57] Ibid., 122.

[58] Ibid., 121 (emphases in original).

[59] Ibid., xiv-xv.

[60] Canguilhem, *The Normal and the Pathological*.

[61] Foucault, *Abnormal*, 49-50.

[62] Ibid., 50.

[63] The distinction between illness and disease is frequently equated with the difference between an individual's phenomenological experience of pain, chronic conditions or medical treatments and the physician's "objective," scientific approach. The seeming chasm between these two perspectives is commonly blamed for the "cold" bedside manner of many doctors, but it is also seen as the impetus for new forms of patient care, as well as the increasing social research

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focus on patients' experiences. For example, in his book *The Illness Narratives*, physician Arthur Kleinman explores individuals' accounts of illness in order to understand (and disrupt) "the difference between the patient's experience of illness and the doctor's attention to disease" (xii). As Kleinman concludes, "when we take as our starting point the meaning of illness experiences, then our very understanding of medicine is challenged" (xiv). See also the following examples of patient-centred writings: Abraham, "'Where Crowded Humanity Suffers'"; Frank, "The Body as Territory"; and, Weaver, " Finch the Spastic Speaks."

[64] Armstrong, *Political Anatomy*, 6.

[65] For detailed Canadian statistics on these trends, see Lindsay and Almey, "Health."

[66] See, for example, Arksey and Hirst, "Unpaid Carers' Access"; Moen, Robison and Dempster-McClain, "Caregiving and Women's Well-Being"; and, Wellman, "Hanging in the Balance."

[67] Osborne, "On Anti-Medicine," 32.

[68] Ibid., 43.

[69] Foucault, *Birth of the Clinic*, xviii.

[70] Waugh, "Postmodernism and Feminism?," 344.

[71] Armstrong, *Political Anatomy*, 6.

[72] Ibid.

[73] Ibid., chap. 4, esp. 34-41.

[74] See note 44 above.

[75] Armstrong, *Political Anatomy*, 40.

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[76] Foucault, *"Society Must Be Defended"*, 245.

[77] Ibid., 246-247.

[78] Ibid., 250.

[79] Ibid.

[80] Ibid., 250-252.

[81] Ibid., 252.

[82] Ibid., 253.

[83] Ibid., 252-253.

[84] See, for example, Buttriss et al., "Successful Ways to Modify Food Choice"; *Economist*, "Fat of the Land"; Ko, "Time for a Fat Tax?"; McGovern, "A Clear and Present Danger"; Rauch, "The Fat Tax"; Riley, "Fat Tax Proposals"; and, Tumulty, "The Politics of Fat."

[85] Haraway, "Cyborg Manifesto," 245, note 4, emphasis in original.

[86] Chatterji, Chattoo and Das, "The Death of the Clinic?," 171.

[87] Ibid., 172.

[88] Alesse® is a female contraceptive drug. As a personal reflection, I have seen Alesse® advertisements in several women's washrooms. See the Wyeth Laboratories (manufacturers' of Alesse®) website for information on the drug itself: Wyeth.com, "Wyeth Family of Products," http://www.wyeth.com/products, accessed July 12, 2006.

[89] Actress Kate Winslet was photographed, in lingerie and stiletto heels, for the cover of the February 2003 issue of *British GQ* magazine. Controversy erupted, however, when the issue hit stands, and it was revealed that Winslet's thighs had

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been digitally slimmed without her authorization (at least, according to some sources). See *British GQ*, February 2003, cover. For commentary and discussion of this incident, see Bordo, "Empire of Images"; *Daily Mail*, "Kate Loses Her Curves"; Feinstein, "Kate Winslet: 'I'm Proud of My Body'"; Freydkin, "Doctored Cover Photos"; and, *USA Today*, "Ideal vs. Real Women."

[90] Foucault, *Birth of the Clinic*, 3-4 (emphases in original).

[91] Ibid., 112-118.

[92] Mulvey, "Visual Pleasure."

[93] Denzin, "Birth of the Cinematic Surveillance Society," 99-100, 109-120.

[94] Ibid., 120.

[95] Butler, *Gender Trouble*, 129.

[96] Ibid., 134.

[97] Ibid., chap. 1 and 128-141. See also Butler, "Imitation and Gender Insubordination."

[98] Butler, *Gender Trouble*, 137.

[99] Ibid., 134-135 (emphasis mine).

[100] Armstrong, *Political Anatomy*, 26.

[101] Foucault, *"Society Must Be Defended"*, 251.

[102] Foucault, *Discipline*, 139.

[103] See, for example, the following for commentary on the derision toward obesity and resistance against this norm: Braziel and LeBesco, *Bodies Out of Bounds*; Kulick and Meneley, *Fat*; Sobal and Maurer, *Interpreting Weight*; and, Sobal and Maurer, *Weighty Issues*.

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[104] See note 2 above.

[105] See, for example, Abraham and Llewellyn-Jones, *Eating Disorders: The Facts*; Bruch, *The Golden Cage*; Brumberg, *Fasting Girls*; Falk, *The Consuming Body*; Gremillion, "Psychiatry as Social Ordering"; Polivy and Herman, "Diagnosis and Treatment of Normal Eating"; and, Turner, "The Discourse of Diet."

[106] See, among others, Bartky, "Modernization of Patriarchal Power"; Bordo, *Unbearable Weight*; Brown and Jasper, *Consuming Passions*; Chernin, *The Hungry Self*; Chernin, *The Obsession*; Fallon, Katzman and Wooley, *Feminist Perspectives on Eating Disorders*; Gremillion, *Feeding Anorexia*; Hepworth, *The Social Construction of Anorexia Nervosa*; Malson, *The Thin Woman*; Nasser, *Culture and Weight Consciousness*; Orbach, *Fat is a Feminist Issue*; and, Thompson, *A Hunger So Wide*.

[107] Rothblum, "'I'll Die for the Revolution," 70-71.

[108] See, in particular, Bartky, "Modernization of Patriarchal Power"; and, Bordo, *Unbearable Weight*.

[109] See McLaren and Kuh, "Body Dissatisfaction"; and, Polivy and Herman, "Diagnosis and Treatment of Normal Eating." See also the "Pro-Anorexia" chapter, notes 113-115.

[110] Foucault, *Discipline*, 139.

[111] Brumberg, *Body Project*, 97-100

[112] Ibid., 128.

[113] Ibid., 128-137.

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[114] Bordo, *Unbearable Weight*, 186-7.

Chapter 2: Re/forming the Anorexic "Prisoner"[1]

When I first looked at the medical protocols for the inpatient treatment of anorexia nervosa, I was both fascinated and disturbed by the eerie parallels between these protocols and Michel Foucault's notion of panoptic disciplinary power. These protocols employ various tools of surveillance and routinization as a means to "cure" the anorexic patient, and do so in ways that are strikingly reminiscent of Foucault's description and use of Bentham's panopticon—that all-seeing, idealized prison in which the jailer is neither seen nor heard, but in which the prisoner is always observed and hence brought under control. The difference in the case of the medical protocols was that the "prison," so to speak, was the inpatient treatment centre and the anorexic woman[2] was the prisoner.[3] To me, these treatment protocols revealed a certain perpetuation of the social disciplinary control over women's bodies via mainstream medicine.

Following feminist analyses that identify control over the body as a central issue in anorexia, I undertake a close examination of both the disciplinary and normalizing force of such medical treatment regimes. Specifically, my analysis exposes the normalization of women's bodies and practices as both an implicit and explicit goal of these regimes. In contrast, I read anorectic practices as a threat to hetero-patriarchal social formations precisely because they represent women's seemingly autonomous manipulation of their own bodies. Read from a feminist and Foucauldian perspective, anorectic practices violate the disciplinary boundaries of the contemporary "docile" female body in that they replicate a traditionally male role: control of the female body. They speak to the complex contradictions embedded in women's disciplined conformity to cultural norms of femininity. In turn, the medical treatment protocols for anorexia are a means by which women are returned to the realm of such masculinist control, to the multiplicitous everyday spaces of the postmodern cultural clinic. Upon successful treatment, anorexic women again become potential reproducers, behave in socially appropriate ways, and develop socially normative relationships with their bodies and food. Exposing the convergence of medicine and beauty, the medical treatment of anorexia seeks to maintain a feminine form of bodily discipline. The "prison" of the inpatient treatment centre seeks to "re/form" its anorexic prisoner.

Positioning the Anorexic "Prisoner"

First, I want to set some parameters for my analysis, and position it in relation to various feminist and medical perspectives on the treatment of anorexia. Briefly, over the last 150 years, approaches to the treatment of anorexia have varied greatly, from purely physiological protocols to depth psychoanalysis, behaviourism and more cognitive-based therapies. Underlying these diverse approaches is the unsettling fact that none have provided a "cure" for anorexia. Beginning in the late nineteenth century, biomedical models saw anorexia as an internal biological dysfunction best addressed with various physiological treatments (including pituitary therapies, electroconvulsive therapy and corticosteroid drugs). These treatments continued, and some continue still today, even though their efficacy came under question.[4] Freud's psychoanalysis provided a drastic shift away from biomedical approaches, and located the cause of anorexia deep in the psyche of the individual instead of in the body. Behaviourist approaches arose in the 1960s, with the development of operant conditioning. Models of positive (and negative) behavioural reinforcement came to the fore, and still permeate many inpatient treatment regimes, although now often in concert with more contemporary psychotherapies.[5] Critiques of behaviourist treatments, the contemporary rise of eating disorders, and the development of various psychotherapeutic models led to a wide range of treatments for anorexic behaviours, many of which draw on these earlier approaches. Such treatments include family systems models and other family-oriented therapies, psychodynamics, group therapy, woman-centred therapy, self-help programs, and twelve step programs.[6]

Today, many inpatient treatment centres for eating disorders follow the cognitive-behavioural therapy model (CBT) for treating both anorexia and bulimia.[7] CBT is a multi-dimensional approach that incorporates psychotherapeutic, psychoeducational, biomedical, and behaviourist paradigms.[8] Mitchell and Raymond note the wide variation in treatments employed by programs using a CBT approach,[9] and Wonderlich et al suggest that the CBT model can be modified for use with particular sub-groups of eating disordered patients.[10] The inpatient treatment protocols for anorexia analyzed in this chapter generally fall under the CBT model.

Despite this development of more nuanced, multi-dimensional approaches, the inpatient treatment of anorexia has come under increasing scrutiny. For instance, the coercive and compulsory treatment of anorexic women is an issue of considerable ethical concern,[11] with the forced naso-gastric re-feeding of severely health-compromised or non-compliant patients being of particular debate.[12] High relapse rates after inpatient treatment are also troubling, as are the disproportionately high death rates for anorexic women. With mortality rates higher than for any other psychiatrized illness, research suggests that between 5 and 20 percent of anorexic individuals die from their practices, with the complications arising from anorexia contributing to these unfortunate findings.[13] On a more positive note, mainstream eating disorders practitioners are beginning to consider issues influencing treatment, such as the therapist's role and attitudes toward the patient, the impact of the therapist's gender, and the power dynamics of treatment.[14]

Feminist theorists, researchers and therapists have taken issue with these approaches for a variety of reasons. First, although many medical advances greatly help women, and many individual physicians assist and support women, a large body of literature now attests to the collusion of medicine and hetero-patriarchy, resulting in the often punitive force of the medical establishment in women's lives and lack of attention to women's health issues. Developing alongside Cartesian dualism, the binary logic of the medical model discursively positions women as pathologized objects requiring medical intervention, as lesser and dysfunctional versions of the healthy male norm.[15] Further, the medical pathologization of eating disorders is of particular concern.[16] By applying the logic of medical pathologization to eating disorders, feminists charge that medicine substantively addresses neither the social and cultural contexts in which eating disorders arise nor the experiences of individual women with eating disorders.

In fact, many scholars and therapists assert that contemporary treatment regimes often replicate the social conditions which inform anorexic practices, instead of alleviating them. As Robin Sesan states, "the decision to recommend inpatient treatment for eating-disordered clients is a difficult one for many mental health professionals. It becomes an even more complicated and conflictual decision for feminist therapists, who are concerned about the oppressive nature of inpatient settings, which all too often replicate destructive patriarchal patterns."[17] For Sesan, it is not only the oppressive nature of inpatient treatment that is concerning, but also the convergence of treatment regimes with normative standards of femininity: "by narrowly defining the acceptable form for a woman's body, current inpatient programs collude with oppressive standards for thinness."[18] Similarly, Helen Gremillion argues that treatment regimes replicate current social and cultural expectations that women should be thin and fit by explicitly embedding these norms into treatment protocols. "Psychiatric treatments for anorexia," she writes, "invigorate contradictory cultural axioms about, for example, feminine fitness and individualism, not only recreating but also intensifying patients' historically particular sociocultural conflicts."[19] The inpatient treatment of anorexia is a distinctly gendered undertaking that replicates and extends the cultural convergence of medical power with the hetero-normative standards of feminine beauty.

While scholars have applied Foucault's notion of the panoptic disciplinary society to anorexia, arguing that anorexia is a disciplined exaggeration or crystallization of the cultural contradictions of embodied femininity,[20] anorexic treatment centres are also identified as distinctly disciplinary environments.[21] Clinical routinization, surveillance and the normalizing gaze of the physician replace the self-discipline that is read by the medical model as lacking in anorexic patients, although many feminist scholars understand anorexic practices as complexly entwined with issues of self-surveillance and control. In the terms of the postmodern cultural clinic, anorexic women's incorporation of the altered medical gaze is inseparable from their disciplinary practices. As a regulatory mechanism, however, inpatient treatment protocols seek adherence to particular disciplinary goals, goals seen as distinct from anorexic practices.

In response to these concerns, alternative critical feminist approaches are being developed that disrupt entrenched traditional hierarchies of male/female, subject/object, illness/health, physician/patient, therapist/client, and thereby disrupt the positioning of anorexic women as observed medical objects.[22] For instance, emerging narrative approaches to eating disorders for therapy, theorizing, and research take a woman's individual story of anorexia as their focus, rather than observing her pathological behaviour in order to cure "it." This kind of approach necessarily acknowledges the complex sociocultural connections and contradictions between anorexia, therapeutic treatment, and women's lived experiences.[23]

My analysis of inpatient medical protocols for anorexia precisely exposes the concerns over control, objectification, and alienation that are embedded in the mainstream medical perspective on anorexia. Each medical protocol examined and each instance of its practice is a moment in which a particularly gendered re-disciplining of the anorexic individual is sought. In the scope of my larger project, these protocols also materialize the disciplinary impetus of the postmodern cultural clinic against the individual woman's incorporation of the altered medical gaze and her displacement of the clinical moment: in the context of the inpatient clinic, the individual woman's disciplining of her unruly body is suspect, while the institutional regulation of her practices is considered appropriate.

Specifically, I undertake a discourse and content analysis of treatment protocols to identify not only the actual terms of treatment (i.e., the literal content of documented treatment regimes), but also the underlying discourses that inform them. While discourse analysis and content analysis are often used interchangeably,[24] I also separate them here to highlight the connection between the intended use of these documents (i.e., medical/therapeutic use) and the underlying rhetoric that ties them to broader social apparatuses of power/knowledge. As I outline in my Introduction, texts reveal particular aspects of discursive production. Dorothy Smith argues that they represent institutional hegemonies[25]; and, Shulamith Reinharz suggests that texts can be read as artifacts or remnants of the discursive processes which inform their production.[26]

Regarding anorexic inpatient treatment protocols in particular, certain aspects of the treatment of anorexia will be reflected in documented treatment regimes, while others may be missed. However, once produced, these texts become constitutive of discourse and practice themselves. Hence, they are a means of accessing the dialectic production of the disciplinary and regulatory regimes surrounding the medical treatment of anorexia.

Working from a critical and feminist perspective, my textual analysis seeks to deconstruct the discourses informing medical knowledge of and authority over anorexia. Certainly, the explicit goal of such treatment protocols is to help women, but these medical texts are also an example of the power/knowledge relationship through which women's subordinated subjectivities are produced. With the inpatient treatment of anorexia, the texts of the medical protocols regulate and coordinate treatment across locations; they materialize the abstracted discourse that informs their production; they suggest the technologies and disciplines that standardize the local setting to a broader institutional discourse. Thus, these texts also reflect the distinctive function and discourse of the inpatient treatment centre as an institution. Of course, it is real women who are subject to such regulations and disciplines. As Dorothy Smith states, the application of generalized, abstracted texts to particularized realities "bring[s] external regulation into the immediacy of the everyday/everynight world" of the individual.[27]

My analysis of these protocols as *texts*, then, examines what these texts say about the institutional discourse of inpatient treatment, rather than of women's experiences of these treatment programs, physician's or practitioner's use of these protocols, or the particular, local environments in which these texts are employed. On the surface, these texts are tools for teaching and sharing information. Beyond this explicit purpose, what do these texts tell us about the institutional discourse of inpatient treatment? Which discursive perspectives are materialized through these words, and which are not?

Further, I examine a variety of medical protocols for their representations of intelligible disciplinary apparatuses, but this is not a comprehensive analysis of all treatment regimes. The field of research is narrow. The examples I analyze sometimes represent extremes in the literature and, in other instances, more moderate positions. These particular examples illustrate the range of perspectives within this literature, while still collectively adhering to a largely biomedical approach to eating disorders. As well, they represent a variety of institutional settings and authoritative voices, with both prestigious and lesser known treatment programs included alongside professional organizations (such as the American Psychiatric Association). While there are numerous aspects to the therapeutic treatments for anorexia, my analysis focuses on the theme of productive control which is found collectively throughout this literature. I have selected texts that exemplify this focus, as well as texts that enable Smith's reading of institutional texts as hegemonic representations. In turn, patient surveillance and routinization are examined as exemplars of disciplinary force; measures of recovery are considered in the context of the anorexic woman's return to normative femininity. I thus read these medical texts as sites in which the collusion between the disciplinary regimes of medicine and femininity is particularly exposed.

Finally, while acknowledging the often vital need for medical intervention in the lives of individuals with eating disorders, I am suggesting that standard medical treatments, particularly those of institutionalized settings, reinforce social control over women's bodies and the disciplinary boundaries of normative femininity. Yet, I do not propose a treatment alternative for eating disorders, nor do I examine the experiences of individual women with medicalized treatment of eating disorders. These are vital issues that rest outside the parameters of my analysis, but within its scope of concern. Rather, my analysis is textual, discursive and theoretical; it is a cautionary deconstruction of mainstream medical treatment protocols for anorexia.

It is also not my intention to condemn individual physicians and other health practitioners working in the field of eating disorders, but to problematize the systems of power/knowledge in which they work. I do not believe that physicians, nurses or therapists who use these protocols intend their patients to become "prisoners" of normative femininity; they desire their patients' recoveries and continued wellness. Yet, the textual representations of anorexic treatment reveal a collusion between medical discourse and social disciplinary regimes of femininity. The medical treatment of anorexia is informed by such hegemonic power structures, as are all areas of social life to varying degrees. Particular instances of anorectic treatment, though, become mechanisms by which these disciplinary power relations are hidden but simultaneously perpetuated; the physician's desire to cure the anorexic woman becomes a discursive mask for the normalizing—and punitive—expectations placed on all women. When pathologized under the medical gaze, anorexia becomes an individual pathological phenomenon, muting the underlying social reality of women's embodied experiences of anorexic practice. With this displacement, the medical practitioner may become another "pawn" of the hegemonic apparatuses of patriarchy. As Foucault states, "power relations are both intentional and nonsubjective."[28] A broader discourse is at work in the inpatient treatment of anorexia in which health professionals are not knowingly embroiled.

Again, I hope to avoid superimposing the medical practitioner directly onto the regulatory regimes of normative femininity, in part, by focusing on treatment protocols rather than the individuals administering these protocols; but, to the extent that actual individuals do administer such programs, I do not see them as direct agents of this dominant and dominating discourse. To be clear, my intention in exposing medicine's usually invisible collusion with hetero-patriarchal social control is to disrupt the social mechanisms that are enmeshed with anorexia and its treatment. Given the growing incidence of anorexia and other related eating problems, as well as the high relapse and death rates of anorexic women who have undergone inpatient treatment, this discursive collusion needs to be laid bare if the material consequences of its oppressive force are to be challenged. It is these terms that both motivate and bracket the following analysis.

The Analogy of the Panopticon:
Framing the Re/formation of the Anorexic "Prisoner"

While on the surface they appear to be a curative for such practices, the medical treatment protocols for anorexia are an explicit site of the disciplinary normalization of women—a site of the postmodern cultural clinic. In contemporary society, diffuse and multiple disciplinary regimes have supplanted overt social control. Bentham's literal Panopticon has been translated into the constant threat or suggestion of surveillance upon the individual—Foucault's panopticism. With the treatment of anorexia, though, this shift to diffuse power has been disrupted. The anorexic woman has taken on the traditionally masculine and heteronormative role of controlling her (female) body. This violation of hegemonic control, in turn, prompts medical treatment protocols which serve as an explicit mechanism for returning the anorexic woman to the "fold" of intelligible disciplinary regimes. The Panopticon of medical treatment becomes explicit to this end, ensuring the anorexic woman's conformity to the panoptic force of femininity. Foucault, in fact, identifies medicine as a key disciplinary mechanism through which such normalization is produced.[29] This dual construction of a literal medical Panopticon, coupled with medicine as a panoptic disciplinary mechanism, perpetuates the normative subjectification of the anorexic "prisoner" in very specific ways.

As discussed in Chapter One,[30] this disciplinary panopticism has merged with the legitimized authority of the medical gaze. Just as the faceless gaze of society surveils women more fervently than it does men, so too does the masculinized gaze of the medical apparatus. The authority of medical vision is now fused with the rhetoric of "health," expanding the imbalance of the clinical moment beyond the traditional confines of the clinic and entwining the medical gaze with the disciplinary gazes of social life. Thus, when individuals incorporate this gaze, they take on the punitive impetus of both disciplinary and medical regimes. With normative femininity in particular, the masculinist grounding of medical epistemology extends as well the binary hierarchy of normal/pathological across the social hierarchy of gendered identity, infusing women's practices of this gaze with the inferiorization of the feminized body-subject. Thus, women's self-disciplinary practices are expanded and enhanced by the convergence of medicine and beauty, sharpening their punitive force in the lives of women.

Yet, these same practices may signify pathology under the medical gaze. With the inpatient treatment of anorexia, the medical gaze discerns pathology on the basis of behaviour, practices, disease, or any other criteria subsumed under medical authority.[31] While the disciplinary regimes of normative femininity provide anorexic women with a particular mechanism of both control and resistance,[32] this same feminized disciplinarity becomes evidence of abnormality. All medical encounters operate on the medical epistemological premise of pathologization; but, the hospitalization of the anorexic woman brings together medicine's explicit force as a literal Panopticon, in which the patient is under observation, and the panoptic discipline of normalization. The convergence of medical epistemology with the disciplinary apparatuses of normative femininity is materialized in medicine's legitimized authority over the individual anorexic patient, returning this cultural convergence to the space of the clinic.

The medical model for normality positions the anorexic woman as an already-pathologized object of medical intervention. Discursively at least, she is the abject, pathologized foil to the "model man" of modern medical epistemology. Her female status places her under the scope of the panoptic medical gaze; her anorectic practices further pathologize her through her "failure" to conform to the standards of normative femininity (at least, in the discourse of hegemonic medicine). Specifically, anorexia has been described as an exaggerated extension of normative "feminine" behaviour. Susan Bordo, for instance, identifies it as an "overdetermined symptom" produced by sociocultural stresses such as the cult of feminine thinness[33]; and, Kim Chernin suggests it is an embodied, but conflicted, response to the constraints placed on women's wants, needs, and desires.[34] One specific element of this anorectic response, however, is its extension of the longstanding cultural desire to escape the "prison" of the unruly (female) body through the will of the (male) mind, a pursuit which temporarily provides the anorexic woman access to masculinized control.[35]

Once accessed, however, the anorexic woman becomes labeled by the medical establishment as a "patient" and can be drawn into the Panopticon of inpatient medical treatment. Once subject to the panoptic (and masculinized) medical gaze, the anorexic woman becomes a discursive patient/prisoner of medicine's panoptic force. Hence, my identification of the "anorexic prisoner" is three-fold: she is struggling with her own (culturally constituted) desire to overcome the prison of her unruly female body; her pathologization for these efforts draws her into the "prison" of medical panopticism; and, once "re/formed" from her pathological state, she returns to the more subtle, though no less ever-present, panoptic regime of normative femininity. And, yet, her retierative failures ensure her continued subjectification with the heteronormative regimes of feminized identity.

Control in Treatment Protocols: Re/producing Panoptic Discipline

In line with the productive form of contemporary disciplinary regimes, the panoptic discourse surrounding the anorexic patient/prisoner is practiced (and thus reproduced) in explicit, almost excruciating detail. Such detail masks the operation of panopticism, but it simultaneously reproduces the power/knowledge apparatuses with which it is embedded. For example, the policy statement for Weight Adjustment and Maintenance, for Inpatient Protocols, of the University of Iowa Health Center Eating Disorders Unit, states that

> inpatients with [eating disorders] are guided to achieve standard, normal weight for height as readily as permitted by their physical status. They are protected from abnormal behaviors, such as inappropriate choice of foods, bingeing, purging, or excessive exercise, as they progress toward normal weight. At normal body weight, they practice maintaining their weight and improving their capacity to eat normally and think in a healthy way about body size and shape. For the sake of (1) agreement among staff members, and (2) improvement in their illness, patients require a treatment regimen that is consistently adhered to, follows simple rules, and is described in considerable detail.[36]

As this statement illustrates, the treatment of patients with eating disorders is a highly regulated undertaking. Under a detailed, yet simple, regimen, these patients will be "guided to achieve normal weights," "protected from abnormal behaviors," and returned to "normal" thinking, eating and body size. A key element of this process is that it is invisible to the patient: only staff are to be aware of this treatment mandate, with information only to be shared with patients and their families in a "systematic and planned manner."[37] This policy mandate establishes the treatment setting as a panoptic space in which only staff know the full set of rules and regulations to which patients are required to adhere.

What is additionally deceptive and simultaneously revealing in this statement is its paradoxical construction of the patient. On the one hand, patients themselves will "practice" new ways of behaving, while on the other hand, they are disassociated from their "abnormal behaviours." Put another way, the patient is connected with the desired outcomes of "normal" thinking, eating and weight, and is disconnected from the "abnormality" of "disordered eating." This construction infuses the disciplinary standards of femininity with the paternalistic authority of medicine in order to separate the normal from the pathological. In so doing, the anorexic patient/prisoner is subjectified as unable to control her abnormal behaviour, even though anorectic practices often centre on issues of control; and, therefore, she requires the normalizing intervention of the medical system.

Attached to this particular policy mandate is a set of procedures for the treatment of anorexic inpatients, comprised of seven sections and 87 separate guidelines for the treatment of patients.[38] Though this extensive list does not include detailed plans for the administration of medications, medical procedures, needed surgeries or therapy content, it does provide a blueprint for patients' weight maintenance, eating and exercise practices, and contact with other individuals, including physicians, nurses, therapists, friends and family.

I will address certain aspects of this plan below, along with other treatment examples, but the panoptic and disciplinary impetus of this regimen is explicit. For example, Foucault states that the success of the Panopticon is achieved in part through its ability to hide those individuals who observe prisoners, as well as their intended actions upon prisoners. In contrast, it makes prisoners fully visible to the observer and, consequently, creates an automatic functioning of productive power.[39] The Iowa Health Center procedures replicate these asymmetries in various ways. For instance, while patients will be weighed upon admission, the following morning, and Mondays, Wednesdays, and Fridays thereafter (unless otherwise indicated), they will always be weighed with their backs to the scale.[40] Furthermore, "*no information about weight (goal range, current weight, increases or decreases) is given to patients or families by any staff member*."[41] Similarly, "*no information about energy intake (calorie level) is discussed with patients. They have no access to written information about calories*."[42] Even when independent "therapeutic leaves of absence" from the centre are allowed (and these never occur when a patient is under observation), nurses are instructed to have no direct discussions with patients about such leaves. Instead, they are to acknowledge the receipt of a patient's request for leave, but discuss it only with the treatment team, of whose members only the physician has the authority to grant a request.[43]

In their overview of treatment for adolescents with anorexia, Patel, Pratt and Greydanus similarly suggest that "because these patients are constantly attempting to retain control, it is important for each member of the management team to clearly understand his or her role . . . . The team should convey a coherent philosophy and plan for treatment. Patients may seek to split the management team to retain control."[44] Like the Iowa Health Centre protocols, they advocate consistent weighing practices, but give some consideration to how these procedures may affect the patient. They suggest weighing patients daily, "postvoid and on the same scale at the same time of day," preferably in the morning and before breakfast. But, they allow that "some patients prefer (and there is little reason to deny their preference) being weighed every other or every third day. This should be individualized but in keeping with general principles of giving patients as much control as possible."[45] With this thoughtfulness in place, however, deception on the part of the patient is still anticipated. For instance, patients may "overload," a practice that involves drinking excessive amounts of water or placing heavy objects in one's clothing prior to weigh-ins. Thus, the "patient should be weighed lying down in [a] light gown without underwear—this way, one does not have to invade patients' privacy to search for objects in bras and so forth." Further, Patel, Pratt and Greydanus suggest using a urine-specific gravity test to determine excessive water intake.[46] In other words, if the patient deceives the physician, the physician still has the ability to uncover the truth.

The treatment protocols at the Eating Disorders Program of Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana, follow similar weighing procedures, with parallel concerns about patient deception. As Stewart and Williamson state of the program's protocols,

> patients are weighed in a hospital gown (with no other clothing on of any kind). Specification of a hospital gown was added to the weighing protocol due to patients' propensity to place heavy objects in undergarments while weighing. Patients are weighed with their back to the scale to insure accuracy and break the obsessive need to know specific numbers. Only the patient's doctor or dietitian is allowed to discuss weight issues with the patient. This rule is used to avoid unnecessary discussion of body weight goals and rate of weight gain, as well as to provide consistency with whom these issues are discussed.[47]

Again, patients face away from the scale during weighing, and access to information about weight is tightly controlled.

As these examples illustrate, the traditional hierarchy of medical authority is deliberately invoked in treatment protocols—the physician, or perhaps dietitian, has ultimate control—but a kind of multi-tiered Panopticon is also constructed, operating on a standard of uni-directional, highly controlled communication. Under this system, the anorexic patient can be read as analogous to the observed prisoner, surveilled by the regimes to which she is subjected and imminently subject to their intervention. The various members of the treatment team gaze back upon this patient/prisoner with an exposing medical gaze, both monitoring and modulating the minute details of this patient/prisoner's bodily practice. Ideally, nothing is hidden from the gazers, but everything possible is hidden from the anorexic patient/prisoner.

Surveillance

Detailed methods of surveillance reinforce this panoptic medical gaze. Not only is the physician given legitimate authority to determine what is (and what is not) "normal" under the general rubric of medical knowledge, but this authority is greatly expanded in the inpatient setting for the treatment of anorexia. Compared to an average interaction in a doctor's office, the inpatient anorexic woman is subject to strikingly disproportionate levels of direct (and often covert) observation. Her circumstance is disproportionate on at least two levels. First, "standard" patients may have greater success at controlling what they reveal to their physicians insofar as the often "confessional" form of doctor-patient interaction allows them to decide of what they will speak. Conversely, as discussed above, medical tests and technologies may reveal what has been concealed from a physician, but the patient's initial choice remains. Second, as the large majority of those involved with anorectic practices are women, an additional scrutiny is already established prior to the inpatient setting. Numerous feminist researchers have documented the negative relationship between medicine and female patients, a primary element of which is the socially legitimized medical authority over women's bodies.[48] Perhaps as a result of the productive force of medical discourse and the frailty assigned to women through normative femininity, this negative relationship has ample opportunity to be reinforced. As discussed in Chapter 1, women generally visit doctors more frequently than men, and also have a greater number of secondary interactions with physicians (via their roles as caregivers to children, spouses and ill parents).[49] Certainly there are exceptions to this generalization, as well as exceptional physicians, but the differential (and often detrimental) treatment of women and their bodies by the medical profession is now well documented. Hence, when the anorexic woman enters the inpatient treatment setting, she is entering a domain in which well-established patterns of imbalanced, gendered relations are practiced, relations which are entangled with the authority granted the physician. These relations, in turn, expose the anorexic woman to medicine's collusion with broader regulatory regimes that survey women's bodies for the purpose of disciplinary normalization.

At the Eating Disorders Program of Our Lady of the Lake Regional Medical Center, for instance, 24-hour care is utilized for the acute inpatient treatment of severe and medically unstable patients. Specifically, "the constant supervision of nursing care is necessary to restore physical and mental health. The focus on inpatient treatment is 'food as medicine' . . . . In addition, the 24-hour environment provides a support system and structure that prevent continued purgative behaviors such as self-induced vomiting, use of diet pills, compulsive exercise, and laxative use/abuse."[50]

Similarly, the Eating Disorders Program at the prestigious Johns Hopkins medical centre advocates a "strict level of constant observation" of the eating disordered patient.[51] More precisely,

> because of the patient's conflicted attitudes toward weight restoration and fears of ingestion of normal amounts of food, the principle of close one-to-one nursing supervision has continued to be strongly emphasized at Johns Hopkins Hospital. Beginning, however, with a very staff-intensive, literal, one-to-one supervision of patients with eating disorders; having a separate primary nurse for each patient; and choosing a single nurse for supervising a small group of patients while eating has proved to be comparably satisfactory. Instead of a variable and very individualized approach to nursing supervision, a protocol has been established in which strict 14-hour (8 a.m. to 10 p.m.), continued, direct observation of patients has been instituted and is maintained until patients are at their goal weight.[52]

The relaxing of round the clock surveillance comes with the "reward" of 14-hour per day observation, outside of which the patient would presumably be asleep (and, presumably, still subject to bed checks). The 14-hour per day model also comes with a built-in, ever-present monitor—the nurse, who ensures adherence to *non*-individualized, *non*-variable standards and supervision. The implicit role of the nurse thus becomes not individualized care, but that of a uniform viewer of the anorexic patient/prisoner. The nurse makes the invisible gaze of the medical Panopticon visible, literalizing its force and ever-presence.

This disciplinary "use" of the nurse can hardly be accidental, but it is also fraught with contradictions. Presumably, "the nurse" is discursively coded as female and, in practice, most nurses are women. As an explicit disciplinary agent, this female nurse then becomes a model and advocate for normative femininity:

she is a non-pathologized woman surveying and disciplining the pathologized anorexic patient/prisoner. Yet, she herself is surveyed to ensure her own adherence to appropriate bodily discipline and to the regimes of the medical Panopticon. Paradoxically, she is thus both the gazer and the gazed upon. This surveillance parallels the way in which mothers inoculate their daughters into normative femininity, as well as the sometimes vicious policing of women's embodied femininity by other women, often across cultural demarcations of race and class.[53] The gaze of one subordinated woman—the nurse—is used in this way to subordinate other women, often replicating traditional familial structures that are, ironically, thought to be implicated with anorexic practices. The collusion of the medical Panopticon with patriarchal hegemony infuses the nurse with a kind of authority, but only to the extent that she ensures the disciplinary regulation of the anorexic patient/prisoner and reports any deviations back to the higher authority of the physician. As Megan Warin notes in her feminist analysis of the institutional spaces of anorexic inpatient treatment,

> the psychiatric team . . . becomes the substitute therapeutic family, which takes over traditional gender roles that are assumed to be pathogenic in the causes of anorexia. These pathogenic family relations, as Malson notes, are reported to be 'typical [of] anorexic families' and consist of certain personalities or behaviours (such as dominant mothers, passive fathers and sibling rivalry) (1998: 84-9). Over-involved mothers and absent authoritative fathers are reproduced in a clinical setting through gender hierarchies of staff . . . [M]ost psychiatrists in eating disorder wards are older males, and hold dominant positions of power within the therapeutic family. The majority of nurses, who are intensely involved in the day-to-day care of people with anorexia, are women.[54]

This does not mean that individual nurses desire the panoptic oppression of anorexic women. Rather, the nurse serves as a discursive mediator in a treatment regime that is embedded in the regulatory mechanisms of normative femininity. These mechanisms are then masked by the nurse's conditional medical authority over the anorexic patient/prisoner. The nurse, in turn, masks the more authoritative gaze of the doctor (discursively coded as male), who himself surveys the nurse and the anorexic patient/prisoner. Through this process, the nurse, metaphorically at least, mediates the anorexic patient/prisoner's transition from the medical Panopticon to sociocultural panopticism.

This kind of surveillance is also found in other inpatient treatment regimes. The Iowa Health Center Eating Disorders Unit, for example, implements similarly totalizing schedules of "eating disorders observation" (EDO), variations of which include: 24 hours per day, 8:00 am. – 10:00 p.m., meal time plus 2 hours, meal time plus 1 hour, and meal time only. The standard EDO is 14 hours per day at the Iowa Health Center (8:00 a.m. to 10:00 p.m.), under an extensively detailed observation plan.[55] Here again, the nurse acts as a kind of mute mediator between the patient and the treatment team, but the task of observation is extended to family and friends once visits are permitted by the treatment team. Specifically, "a family member or friend of a cooperative patient may assume the responsibility of EDO on the unit or on hospital grounds if agreed upon by the treatment team and ordered by a physician or psychologist."[56] The more detailed Iowa Health Center procedures thus provide for the future time when the anorexic patient/prisoner will be outside the gaze of the medical Panopticon and under the gaze of an alternative panoptic regime—that of her social world.

Beyond the force of these examples, Anderson notes that continuous video monitoring, as well as the constant measurement of food intake and eating behaviour through advanced medical technologies (the details of which are not provided), are being considered as possible future modifications to such programs.[57] In the meantime, more traditional mechanisms of surveillance are put in place. Of the treatment centres she observed, Megan Warin notes that the physical layout of patients' rooms ensures constant surveillance by nursing staff. For instance, she explains, "single side rooms for in-patients were positioned directly opposite the nurses' stations, and the occupants of each room could be observed around the clock. Doors were not allowed to be closed (although curtains could be used for privacy when patients needed to wash or go to the toilet)."[58] This layout was often ambiguous and confusing, though, as it combined the spaces of the bedroom, bathroom/toilet and eating area. "It was not simply a reversal of the public/private dichotomy, of the private lives of patients becoming public," Warin writes, "but a conflation of practices and spaces: for what was deemed private became public and what would normally be associated with sociality became private."[59]

Routine

The routinization of inpatient time extends panoptic medical surveillance. Eerily paralleling the often minute-by-minute routines of prisoners, the anorexic patient/prisoner is, on the one hand, made to conform to a detailed, time-oriented daily regime and, on the other hand, observed in precise detail in order to record her behaviour against a normative schedule.

First, daily schedules are a prescribed element of treatment into which the newly-arrived anorexic woman is thrust. While allowances are made for severe illness, the normalizing impetus of routine is central to the mainstream medical protocols for the inpatient treatment of anorexia. As the Iowa Health Center protocols state, "consistency of goals and methods is required to keep the focus of treatment on the true issues. This consistency is provided by a protocol that deals with all the routine specifics related to the restoration of weight, exercise, level of observation, and privileges."[60] Again, this program provides a striking example of routinization: operating on a weekly schedule, each day is divided on the quarter-hour, half-hour, or hour; each therapeutic, educational, recreational ("leisure-time skill building"), and meal/snack activity is scheduled—and mandatory.[61]

In a seemingly less restrictive example, Touyz and Beumont suggest that "there is no justification whatsoever for implementing harsh behavioural regimes to punish patients who have not complied with treatment." As such, they advocate a more flexible and lenient approach to treatment.[62] Yet, their "Brief Reward Program" (BRP) illustrates that harsh regimes still have their place for the non-compliant patient/prisoner. Specifically, the BRP divides days and weeks into seven overall elements, including timed showers, leisure activities, therapy sessions, scheduled (and limited) parental visits, and daily weigh-ins. Instead of allocating every minute of time, this program operates on the opposite premise of restricting activity, with enjoyable activities added as rewards for weight gained; any failures to maintain agreed-upon weight gains immediately signal a return to more restrictive stages of the BRP.[63] Further, patients on BRPs are confined to their rooms throughout this process, heightening the effect of the panoptic medical gaze.[64] Overt behaviourist mechanisms of positive reinforcement are thus used more explicitly in this example, but Foucault's panopticism is emulated through the disciplined production of particular bodily practices.

While constant observation has already been shown as the norm for inpatient settings, the treatment protocol outlined by Reiff and Reiff demonstrates how observation is intimately linked with routinization in the inpatient treatment of anorexic women. Twenty-four hour observation is utilized in their treatment regime to produce a minute-by-minute hunger and food intake pattern for each patient, including all foods and beverages consumed (including gum chewed), how consumption occurred, calorie-to-amount ratios, sleep behaviour and dreams, each of which is plotted against the degree of hunger experienced by the anorexic patient/prisoner.[65] While there is room in their analysis for a variety of hunger patterns, this patterning exercise is used in the re-education of the patient/prisoner toward "normal eating." Reiff and Reiff also suggest that all individuals with the same eating disorder share a consistent, but "abnormal," hunger pattern. Conversely, and somewhat paradoxically, they identify predictability as a defining feature of "normal" hunger, but acceptable variations in normal eating do not include predictable disordered eating.[66] In other words, "normal" eating behaviour follows a predictable pattern, with limited allowable variations, but predictable disordered eating can never be "normal." This contradiction suggests that the only acceptable forms of "normal" eating are those which conform to such medicalized definitions, again demonstrating the authority of medical knowledge over the anorexic patient/prisoner.

Typically, meal times are also highly routinized; many treatment protocols implement thirty minute time limits for eating and require that meals occur only at scheduled times.[67] Programs such as the Lady of the Lake centre in Baton Rouge also regulate behaviour during meals. Their "therapeutic meal" protocol, for instance, is a time during which "unmindful" behaviours are not permitted, but all other behaviours "should be highly structured."[68] To this end, Stewart and Williamson outline fourteen "strict rules" for this therapeutic protocol.[69] The first three rules are particularly revealing: "1. Patients are not to begin eating their meal until all patients and staff are seated, and the staff member has verified patient food selections with their prescribed meal plan. 2. Once seated at the table, patients will not be allowed to leave the table. 3. The staff member (patients are asked to unfold napkins, lift plates, etc.) will record the percentage of each food and beverage on the patient's tray, before and after the meal. This is so that the dietitian has an accurate record of the amount of food the patient has consumed." Condiment use is measured and strictly regulated, as is water intake, with only one eight-ounce glass permitted per meal (with one "additional glass permitted if prescribed food is eaten"), and no diet beverages, water/sports bottles, hard candy, gum, mints or food from home allowed.[70] To ensure adherence to these rules, therapeutic "meals are supervised by a staff member who has received specific training on how to conduct therapeutic meals"[71]; food consumption is measured and recorded; and, "mindfulness" is an absolute requirement of participation. Should a patient fail to be "mindful," "the patient will be removed and will eat separately from the other group members to avoid contamination of the therapeutic experience for other individuals," where his or her eating behaviours will presumably still be scrutinized.[72] Again, routinization is closely tied to the observation of patients, explicitly linking the surveillance of the anorexic patient/prisoner with the disciplinary production of "normal" behaviours.

Anorectic Recidivism: Failed Patient or Lost Prisoner?

None of the above regulatory mechanisms occurs outside the ultimate goal of normalizing the anorexic patient/prisoner. All of the protocols examined seek to return her to a normative body weight through the disciplined practice of socially and medically appropriate relations with her body, food and other individuals, as evidenced by the achievement of an assigned goal weight. As the American Psychiatric Association's treatment guidelines indicate, "a healthy goal weight is the weight at which normal menstruation and ovulation are restored or, in premenarchal girls, the weight at which normal physical and sexual development resumes."[73] In this definition, recovery is signified by "menstruation and ovulation" or the youthful promise of these bodily practices; and this signification signals the integral connection between "healthy goal weight" and the hegemonic constitution of the "normal" female body as a reproductive body. Returning to an earlier example, the Iowa Health Center policy statement describes recovery as the return to normal weight, at which the patients "practice maintaining their weight and improving their capacity to eat normally and think in a healthy way about body size and shape."[74] Patel, Pratt and Greydanus suggest that comprehensive, multidisciplinary programs should also aim for the "normalization of behavioral, emotional, and social functioning."[75] What the explicit disciplinary mechanisms of intense surveillance and routinization share as an implicit goal, then, is the return of this patient/prisoner to an appropriately "disciplined" bodily form.

Though defined as "normal" in each of these protocols, normative standards of weight are socially, culturally and politically prescribed. While standardized body weight measures have fluctuated historically, both within the niche of eating disorders treatment and in broader social settings, goal weights within the treatment literature are generally based on actuarial tables that have changed little since 1959.[76] Such tables identify goal weight "as a 4-pound range in the desirable weight for a person of medium frame of the same sex and height without shoes and without clothing."[77] It is clearly a normative standard which views all women (and men) in the same way. The more sophisticated Quetelet—or Body Mass—Index (BMI) gives a greater range for ideal weight,[78] but it is preferred by some physicians because it provides "a more precise measure of the degree of underweight or emaciation."[79] In a sense, then, the BMI quantifies *degrees* of anorexia.

The achievement of normal weight by the anorexic patient/prisoner is premised on her successful adherence to the regimes of the medical Panopticon, with her maintenance of normative feminine bodily practices resting on her continual subjection to social disciplinary regimes. Her release from inpatient treatment requires, in other words, her willing transition from the panoptic medical gaze to the panoptic power of the disciplinary society. As Foucault states of panopticism, "in order to be exercised, this power had to be given the instrument of permanent, exhaustive, omnipresent surveillance, capable of making all visible, as long it could itself remain invisible. It had to be like a faceless gaze that transformed the whole social body into a field of perception:

thousands of eyes posted everywhere, mobile attentions ever on alert, a long hierarchized network."[80]

The ultimate physical marker of a successful recovery, though, is the return of menses,[81] signalling the return of the anorexic patient/prisoner to the heteronormative feminine state of potential reproducer. Within the analogy of the anorexic prisoner, the anorexic woman's desire to control her unruly, imprisoning body rids her of this distinctly female marker. Its absence signals her violation of both female bodily boundaries and the disciplinary regimes of the postmodern cultural clinic. Solidifying the analogy of the Panopticon, her continual renunciation of these violations is reinforced by the constant threat of a return to treatment. Further, the positive productive force of medical discipline establishes female reproductive potential as a positive goal for the anorexic patient/prisoner but, paradoxically, this reasoning fails to see its own panoptic operations. The medical Panopticon cannot, or does not, acknowledge its collusion with, and simultaneous constitution through, larger social discourses. As such, it cannot acknowledge the sociopolitical statement of protest to be read in the politicized anatomy of the anorexic woman.

Thus blinded, the medical Panopticon of inpatient treatment for anorexia instead reinforces the discourses informing anorectic practices. High rates of relapse or, to continue the prison analogy, "recidivism," are the result. Within the medical literature, failed "mastery" over the body is the core reason for this "anorectic recidivism," with the particular manifestations of relapse coalescing around inappropriate bodily practices[82]: the anorexic patient/prisoner has failed to control her body appropriately, and this failure prompts the normalizing intervention of the medical establishment. Taking up the sociocultural theme of control over the body, this medical discourse first penalizes the anorexic woman for adhering too well to the desire for bodily control, and then demands her re/formed adherence to this same impetus.

If, as Susan Bordo contends, anorexia is an embodied, inchoate protest against the violence of femininity, to be read in hyperliteral form on the bodies of these women,[83] then anorectic recidivism is saying that women still face a constraining social force when they leave treatment. However, psychomedical models of disordered eating rarely consider the social in any substantive way. Thus, they are not "treating" the appropriate "cause" of disordered eating practices. Instead, their continuous surveillance of the anorexic patient/prisoner, and their disciplining of her bodily practices through routinization, reproduce the conditions to which her anorexia speaks. The pathologization of this woman by medical discourse converts her into the patient/prisoner, and masks the feminized subjectivity that is at the centre of her anorectic struggle. In so doing, the medical treatment regimes for anorexia succeed in perpetuating apparatuses of power/knowledge that rely on a constrained feminine body-subject for their operation. The institutional discourse of this treatment is thus revealed as a discourse of discipline, precisely the embodied, disciplined incorporation by anorexic women of the normative standards of femininity.

Anorectic recidivism, however, challenges this discourse by serving as an embodied re-articulation of the anorexic woman's protest against normative femininity: “where there is power, there is resistance,” Foucault reminds us.[84] Hence, the multiple workings of power in the medical Panopticon include the seizing of bodily control by the anorexic patient/prisoner, a discipline at which she is already practiced and which the panoptic force of her inpatient treatment has encouraged, albeit with different aims.[85] She has already incorporated the multiplicitous gaze of the postmodern cultural clinic, and mastered its disciplinary prompts. The unfortunate paradox of this response is that the anorexic woman re-entrenches herself in the power/knowledge apparatuses informing the idealized feminine aesthetic of thinness, an idealization itself now re/formed through the convergence of health and beauty.

Does this mean that the medical Panopticon has failed to re/form its patient/prisoner, or that this medically-constituted patient/prisoner has failed the Panopticon? Or, does anorectic recidivism suggest that a hierarchy exists in the power/knowledge structures of anorexic inpatient treatment which inform the subjectivity of the “anorexic woman”? If the final sign of inpatient recovery is the re-establishment of potential reproduction, then the sociopolitical need for reproductive women appears to be of greater importance in the disciplinary discourse of anorexic inpatient treatment than are the women themselves. The medical Panopticon thereby becomes a means to this broader social end, enveloping medical authority within the hegemonic goals of hetero-patriarchy. As an overt mechanism of control over the anorexic woman, medicine is still granted the authority to subjectify her as a patient/prisoner in order to re/form her reproductive potential. However, its treatment of her is premised on her eventual de-subjectification as a "patient/prisoner" and her return to the larger Panopticon of normative femininity, where her "prisoner" status will cease to be medicalized in favour of a more normative "prison"—that of the inescapable panopticism of everyday life in which feminized identity is produced within the politicized constraints of "whiteness," affluence and hetero-desire. The anorexic woman's recidivism then speaks to this panoptic conundrum: "success" under the panoptic gaze of inpatient treatment ensures that the "faceless gaze" of society will once again be turned upon her. Her return, instead, to anorectic practices speaks to the violence of both gazes: she continues to violate the masculinized control of her female body in protest against the disciplinary panoptic regimes between which she is caught.

Notes

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[1] A version of this chapter has been published. See Bell, Mebbie. "Re/forming the Anorexic 'Prisoner': Inpatient Medical Treatment as the Return to Panoptic Femininity." *Cultural Studies <-> Critical Methodologies* 6, no. 2 (May 2006): 282-307.

[2] In referring to "anorexic women," I acknowledge that there are various identities embedded within such a broad term: as a wide variety of reasons influence women's anorectic practices, a wide variety of women also struggle with such body issues. I work from the perspective that anorexia and other eating problems occur across social groups, locations and delineations, and that individual manifestations of anorexia vary. I thus take up the feminist position that such eating problems are inextricably connected to the sociocultural contexts in which they occur. While anorexic men are also subject to the disciplinary force of the medical Panopticon, I focus here on women since anorexia is largely a practice of feminization. Further, by using "anorexic" as an identifier rather than an identity in itself, I hope to retain reference to the women involved with these practices. Finally, while the medical literature at issue in this paper does acknowledge various aspects of women's identities, it substantively addresses neither the impact of identity on women's particular practices of anorexia nor on their treatment within the medical apparatus: issues of gender, race, ethnicity, sexual orientation, ability, and class are rarely considered significant in these inpatient medical treatment protocols.

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[3] This analogy is in no way intended to erase or dismiss the experiences of women who are imprisoned in penal institutions. Nor do I intend to overwrite the material realities and contexts of their experiences through my analysis. I focus explicitly on the discursive manifestations of Michel Foucault's "panopticism" with the treatment protocols that I analyze. Just as Foucault translates and extends Bentham's literal prison model (the panopticon) to discursive social space and into the disciplinary practices of the individual, I apply Foucault's notion of this broader panopticism to anorexic inpatient treatment, linking the clinic as a panoptic space to the more diffuse panopticism that informs anorexic practices.

[4] Gremillion, "Psychiatry as Social Ordering," 60.

[5] Gremillion, "Psychiatry as Social Ordering." For detailed discussions of the history of the medical treatment of anorexia see also Brumberg, *Fasting Girls*; Saukko, "Fat Boys and Goody Girls"; Silverman, "Historical Development"; and, Sobal and Maurer, *Weighty Issues*.

[6] For discussion of these wide ranging programs, see for example, Brown and Jasper, *Consuming Passions*; Brownell and Fairburn, *Eating Disorders and Obesity*; Brownell and Foreyt, *Handbook of Eating Disorders*; Bruch, *The Golden Cage*; Dolan and Gitzinger, *Why Women?*; Emmett, *Theory and Treatment of Anorexia Nervosa*; Fallon, Katzman, and Wooley, *Feminist Perspectives on Eating Disorders*; Garner and Garfinkel, *Handbook for Treatment of Eating Disorders*; Halmi, *Psychobiology and Treatment*; Kinoy, *Eating Disorders*; Miller and Mizes, *Comparative Treatments*; Orbach, *Fat is a Feminist Issue*; Orbach,

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Fat is a Feminist Issue II; van Wormer, "Hi, I'm Jane"; and, Women's Therapy Centre Institute, *Eating Problems*.

[7] See, for example, Andersen, Bowers, and Evans, "Inpatient Treatment"; Anderson, "Analysis of Treatment Experience"; Fairburn, Marcus, and Wilson, "Cognitive-behavioral Therapy for Binge Eating"; Garner, Vitousek, and Pike, "Cognitive-behavioral Therapy for Anorexia Nervosa"; Roloff, "The Nurse's Role"; Vitousek, "Cognitive-behavioral therapy for Anorexia Nervosa"; Wegner and Wegner, "Cognitive-behavioral Therapy and Other Short-term Approaches"; and, Wright et al., *Cognitive Therapy with Inpatients*.

[8] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 339.

[9] Mitchell and Raymond, "Cognitive-behavioral Therapy in Treatment of Bulimia Nervosa," 308.

[10] Wonderlich et al., "Integrative Cognitive Therapy for Bulimic Behavior."

[11] See, for example, Draper, "Treating Anorexics Without Consent"; Goldner, "Treatment Refusal in Anorexia Nervosa"; Goldner, McKenzie, and Kline, "Ethics of Forced Feeding"; Mitchell, Parker, and Dwyer, "The Law and a Physicall-Ill Patient"; Roberts, "Consent, Refusal and Minors"; Tiller, Schmidt, and Treasure, "Compulsory Treatment"; and, Vandereycken and Beumont, *Treating Eating Disorders*.

[12] See, for example, Yager et al, *Guideline Watch*, 3; and, Patel, Pratt, and Greydanus, "Treatment of Adolescents," 249.

[13] See Neumarker, "Mortality." For more detailed discussion of these mortality figures, see note 107 in the "Pro-Anorexia" chapter.

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[14] Vandereycken and Beumont, *Treating Eating Disorders*.

[15] In a large body of literature, see, for example, Bell, "Reluctantly Finding Woman-As-Death"; Lorber and Moore, *Gender and the Social Construction of Illness*; Lupton, *Medicine as Culture*; Morgan, "Women and the Knife"; Oakley, *The Captured Womb*; Riessman, "Women and Medicalization"; Shildrick, *Leaky Bodies*; Weitz, *Politics of Women's Bodies*; and, Wilkinson and Kitzinger, *Women and Health*. See also Chapter 1, "The Postmodern Cultural Clinic," for more extensive discussion and analysis of the gender binary hierarchy in relation to medical epistemology.

[16] See, for example, Bordo, *Unbearable Weight*; Bray, "The Anorexic Body"; Brown and Jasper, *Consuming Passions*; Fallon, Katzman, and Wooley, *Feminist Perspectives on Eating Disorders*; Gremillion, "Psychiatry as Social Ordering"; Gremillion, "In Fitness and In Health"; Gremillion, *Feeding Anorexia*; Nasser, *Culture and Weight Consciousness*; Saukko, "Fat Boys and Goody Girls"; Saukko, "Between Voice and Discourse"; and, Thompson, *A Hunger So Wide*.

[17] Sesan, "Feminist Inpatient Treatment," 251.

[18] Ibid., 257.

[19] Gremillion, *Feeding Anorexia*, 32.

[20] See Bordo, *Unbearable Weight*, 139-64.

[21] See Gremillion, *Feeding Anorexia*; Gremillion, "In Fitness and In Health"; Malson, *Thin Woman*; Sesan, "Feminist Inpatient Treatment"; and, Warin, "Transformations of Intimacy."

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[22] See Brain, "Anorexia as a Subversive Bodily Act"; and, Bray and Colebrook, "The Haunted Flesh".

[23] See, for instance, Bray, "The Anorexic Body"; de Fabrizio, "Symbolic Disorder"; Gremillion, *Feeding Anorexia*, 193-209; and, Saukko, "Between Voice and Discourse."

[24] Reinharz, *Feminist Methods*, 148.

[25] Smith, "Institutional Ethnography"; and, Smith, *Writing the Social*.

[26] Reinharz, *Feminist Methods*, 149-50.

[27] Smith, "Institutional Ethnography," 34.

[28] Foucault, *History of Sexuality*, 94.

[29] Foucault, *Power/Knowledge*, 107.

[30] In Chapter 1, see especially the section entitled "Birthing the Postmodern Cultural Clinic" for detailed analysis of the convergence of the disciplinary regimes of medicine with feminine aesthetics.

[31] Foucault, *Birth of the Clinic*, chap. 2.

[32] See, for example, Bordo, *Unbearable Weight*; Gremillion, *Feeding Anorexia*; Gremillion, "In Fitness and In Health"; and, Malson, *Thin Woman*.

[33] Bordo, *Unbearable Weight*, 141.

[34] Chernin, *Obsession*.

[35] See, for example, Bordo, *Unbearable Weight*, 144-151; and, Malson, *Thin Woman*, esp. chap. 6.

[36] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 349.

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[37] Ibid., 350.

[38] In calculating this figure, subsections of the procedures were only counted once. For example, in Section B/Nutritional rehabilitation, Regulation 2/Dietary Content, Part A/Physiological considerations, only the five guidelines of "Physiological considerations" were counted, rather than including each of the ascending headings. See Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 349-53.

[39] Foucault, *Discipline*, 200-4.

[40] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 349.

[41] Ibid., 349-50 (emphasis in original).

[42] Ibid., 350 (emphasis in original).

[43] Ibid., 352

[44] Patel, Pratt, and Greydanus, "Treatment of Adolescents," 245.

[45] Ibid., 250.

[46] Ibid.

[47] Stewart and Williamson, "Multidisciplinary Treatment of Eating Disorders – Part 1," 827.

[48] For discussion of the historical and contemporary relationship between women and medicine, see Chapter 1, "The Postmodern Cultural Clinic."

[49] In Chapter 1, "The Postmodern Cultural Clinic," see page 17 and notes 63-64.

[50] Stewart and Williamson, "Multidisciplinary Treatment of Eating Disorders—Part 1," 813.

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[51] Anderson, "Analysis of Treatment Experience," 108 and table 6-3.

[52] Ibid., 108-9.

[53] See, for example, Dworkin, "Gynocide"; Hurtado, "Relating to Privilege"; and, Smith, "Split Affinities."

[54] Warin, "Transformations of Intimacy," 106, citing Malson.

[55] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 351.

[56] Ibid., 351-52.

[57] Anderson, "Analysis of Treatment Experience," 106 and table 6-3.

[58] Warin, "Transformations of Intimacy," 104.

[59] Ibid., 105.

[60] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 333.

[61] Ibid., 334-35 and table 17.2.

[62] Touyz and Beumont, "Behavioral Treatment to Promote Weight Gain," 362-63.

[63] Ibid., 369 and table 19.3.

[64] Bed rest and wheelchair protocols are used to similar effect by some inpatient treatment programs; see for example, Stewart and Williamson, "Multidisciplinary Treatment of Eating Disorders—Part 1," 827-28.

[65] Reiff and Reiff, *Eating Disorders*, 247-48.

[66] Ibid.

[67] See, for example, American Psychiatric Association, "Practice Guideline," Part II. Developing a Treatment Plan, table 1; and, Stewart and Williamson, "Multidisciplinary Treatment of Eating Disorders—Part 2," 838-9. In

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contradiction to these protocols, though, Megan Warin notes that, of the programs she observed, all patients on "bed programmes" (i.e., confined to bed to promote weight gain) were required to eat alone in their hospital rooms as a condition of acceptance into treatment. However, the layout of these rooms ensured continual surveillance. See Warin, "Transformations of Intimacy," 106.

[68] Stewart and Williamson, "Multidisciplinary Treatment of Eating Disorders—Part 2," 838.

[69] Ibid.

[70] Ibid., 839, table 2.

[71] Ibid., 838.

[72] Ibid.

[73] American Psychiatric Association, "Treating Eating Disorders," part D/subsection b.

[74] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 349.

[75] Patel, Pratt and Greydanus, "Treatment of Adolescents," 246.

[76] See, for example, Patel, Pratt, and Greydanus, "Treatment of Adolescents," 250; and, Reiff and Reiff, *Eating Disorders*, chap. 3 and app. A.

[77] Andersen, Bowers, and Evans, "Inpatient Treatment of Anorexia Nervosa," 349.

[78] Abraham and Llewellyn-Jones, *Eating Disorders*, 23-28.

[79] Ibid., 28.

[80] Foucault, *Discipline*, 214.

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[81] See, for example, Crowther and Sherwood, "Assessment," 38.

[82] Zerbe, *The Body Betrayed*, 372-74.

[83] Bordo, *Unbearable Weight*, 175.

[84] Foucault, *History of Sexuality*, 95.

[85] See, for instance, Gremillion, *Feeding Anorexia*, 47. Gremillion notes the adept skill of anorexic inpatients at precisely maintaining or manipulating the goal weight prescribed by their physicians; one patient Gremillion observed subverted "her treatment plan—using it to support her anorexia—even as she highlighted one literal meaning of her admission weight, reading it as (just below) an acceptable maximum, rather than minimum, weight."

Chapter 3: Weighing in on Oprah

> Throughout the years, I've seen Oprah's weight go up and down. And then I remember this summer seeing a recent episode of her show and seeing that she had lost a lot of weight. And she inspired me. If she can do it, I know that I can do it.
>
> Guest confessional from *The Oprah Winfrey Show*[1,2]

Oprah Winfrey's success is staggering. Her nationally syndicated television talk show *The Oprah Winfrey Show*, now in its twentieth season, is seen in over 117 countries and by more than 49 million viewers each week in the United States alone—mostly women.[3] Her website, Oprah.com, "averages 64 million page views and more than three million unique visitors per month"[4]; and, *O: The Oprah Magazine*, which had the most successful magazine launch in recent history,[5] is a top-seller five years later.[6] She received a United Nations' Global Humanitarian Action Award in 2004.[7] In 2005, she was honoured as a "hero and icon" on *Time Magazine*'s list of the most influential people in the world[8]; she was named the most powerful celebrity by *Forbes* magazine,[9] and was not only one of *Forbes*' richest Americans,[10] but also made its list of the world's billionaires with an estimated net worth of $1.3 billion.[11] She is a fierce child advocate, generous philanthropist, award-winning actress, media pioneer, and educator—and, all as an African American woman from humble roots.[12] Winfrey is, indeed, "the queen of all media."[13]

Despite everything that distinguishes Oprah as an individual and pop culture icon, however, her success is premised largely on her personal connection with her viewers. This connection is the basis for Winfrey's ongoing campaign to help women achieve health, fitness and individual success—for every woman to "live her best life." Oprah holds herself up as an example of the success of self-improvement, as well as of women's struggles with their bodies, weight, health and discipline. She advocates embodied empowerment[14] through her own brand of individualistic spirituality, a spiritual and emotional enlightenment that promises to "excavate the real you."[15] Demonstrating the right path to women's individual success through her own example, Oprah becomes a kind of contemporary "everywoman" with whom all women can identify. As Winfrey writes of *O: The Oprah Magazine*, "there's nothing I share on these pages that I haven't gone through or continue to move through myself."[16] To her loyal viewers, she is just like them.

Winfrey's struggles with her weight are a centrepiece of this carefully cultivated identification, at once a point of resonance with women and the hallmark of her call for women's self-transformation. In the following analysis, I examine two intersecting discourses that are exemplified by this merging of women's weight loss and Winfrey's therapeutic narrative of self-help. First, Oprah Winfrey's weight loss campaigns, which themselves merge her personal struggles with her multi-media messages, align women's "health" with "mindfulness," self-awareness and embodied empowerment. Reminiscent of certain second wave feminist perspectives on women's body image issues, these campaigns produce a televisual discourse on weight loss that signifies over-eating as a coping mechanism to deal with emotional trauma and constitutes the resulting "fat" as a barrier to self-fulfillment. While this dialogue carefully skirts critique of the ideal thin feminine aesthetic, it surreptitiously reproduces the idealized thin body by resignifying it as a "reformed" body. As a result, the heavily laden cultural binary of "fat" versus "thin" is reinforced, drawing women back into the power/knowledge apparatus of normative femininity via their own embodied discipline.

Simultaneously, this weight loss dialogue is an exemplar of a socio-clinical discourse that merges the productive power of medicine with the punitive force of contemporary feminine aesthetics—the postmodern cultural clinic. Oprah's weight loss discourse relies and expands on the tenets of medical perception precisely because of its campaign to improve women's lives. In so doing, its rhetoric of embodied empowerment is mediated through social norms of beauty, health and spirituality, producing a socio-clinical discourse through which women discipline themselves in the guise of learning and in the always dubious mode of self-improvement.

Working from a critical feminist perspective, I first establish the parameters of Oprah's weight loss dialogue, exploring specifically its reliance on Oprah's carefully crafted persona and the feminist potential of her televisual discourse. I then outline the terms of the socio-clinical space produced through this campaign. Drawing on Michel Foucault's historical analysis of the "clinic," I examine how expert knowledge, prescriptions for wellness, quantifications of the "reformed body" and Oprah's advocacy of women's health each contribute to the legitimization of her campaign for women's wellness. Reflecting mainstream perspectives on "fatness," this clinical discourse produces a proscriptive response to the "American obesity epidemic." Furthermore, through the reiteration of her own "diet" narrative, Oprah becomes an exemplar of women's "good health." Next, I address the discursive construction of "fatness" through this clinical media milieu, focusing particularly on the contradictory messages of acceptance and vilification that exist in Oprah's treatment of obesity. Finally, I analyze how thinness, and its particular coding as a "reformed" body, reinforces a normative prescription for feminine discipline and embodiment.

Oprah Winfrey's vast cultural resources enable multiple venues for her therapeutic narrative of women's self-help. Many scholars argue that *The Oprah Winfrey Show* and its multi-media offshoots represent a genre in and of itself; it has surpassed the broader genres of talk television, trash television and even self-help.[17] Consequently, it produces a unique set of interconnected narrative streams that distinguishes it from other cultural examples: discursive narratives of the "therapeutic," personal authenticity, black feminism and African American culture are interwoven in the long standing televisual discourses of *The Oprah Show*. As two central features of Winfrey's media empire, articles from *O: The Oprah Magazine* and *Oprah Show* transcripts form an interlinked text which I read as a broader pop-cultural text throughout my analysis. I examine particularly revealing examples of Winfrey's weight loss discourse, and I read across this shared text to explore the thematic multi-media production of Winfrey's "live your best life" campaign. Following Corrine Squire's analysis of *The Oprah Winfrey Show*, I treat these articles and transcripts as a "polysemous, difficult but readable text" that is framed "by broader 'texts' of social power and history" and "suffused with the intensity and fragmentariness of subjectivity."[18] I am not examining women's individual responses to this discursive televisual production, but rather the collisions between medicine and feminine aesthetics that are embedded in its multi-media clinical space. It is precisely these collisions that are hidden within Oprah Winfrey's weight loss dialogue.

Embodied Empowerment and Identifying with Oprah

Before taking even one step, you must sign a contract with yourself that reads: "I, [print your name], hereby commit to 12 weeks of regular vigorous exercise—that's eight workouts a week—and to self-control when it comes to eating. I will be focused on challenging my abilities in the pursuit of elevating my physical performance. In addition, with the exception of three days, I will not indulge in any alcoholic beverages during the 12-week period, regardless of the nature of the temptation. I will also terminate my consumption of all food three hours prior to my bedtime. I will endeavour to be conscious of when and why I eat and will, to the best of my ability, eat simply to satisfy my nutritional needs as opposed to my emotional needs. I will also do my best to make healthful food choices. I realize that this contract is solely with myself and that it carries no rewards, penalties, or punishments other than those associated with the reflection of the strength of my character." Sign and date it. Stick it on your fridge.

From "Lose Weight With Oprah,"
Oprah Winfrey's weight loss "boot camp"[19]

Prostrate at the hair wash station, Oprah Winfrey creeps into my life again. My (absolutely lovely) hairdresser has lost a lot of weight and she's discussing a local weight loss "boot camp" with another client. Without revealing the source of her "plan," my hairdresser says she's exercising eight times a week—without excuses, without fail. She's cut her portion sizes in half, no junk food, lots of water, and no food after 7:00 p.m. She says she started in February 2005. She looks great, and I am appropriately envious (losing weight being one of the things we should envy in our culture, at least under certain circumstances, with certain individuals). She doesn't mention Oprah, but her words are too precise, the regime too particular: I know she's part of Oprah's "boot camp."

With a personal contract to sign and post on the fridge, popular culture icon Oprah Winfrey called on all women to make a commitment to themselves in February 2005. Her "Lose Weight with Oprah" boot camp promised "twelve weeks to a better body."[20] Following the rigorous diet and exercise regime that transformed her own body over the last few years, Oprah led four of her staff through the program on the pages of *O: The Oprah Magazine*[21] and on her nationally syndicated talk show *The Oprah Winfrey Show*.[22] Stating that she still wanted to lose another ten pounds,[23] Oprah lost weight alongside her staffers, as did the thousands of viewers who reportedly lost over a million pounds collectively.[24]

As with many previous weight loss programs championed by Winfrey, Oprah's own experiences framed the campaign. She writes in *O* magazine:

> I was standing on the front porch of my new home in California, the one I've worked on for three years as a gift to myself. I was looking at the mountains folding over on themselves and my yard filled with oak, pine, and redwood trees, thinking how this property is really graced by God, a promised land, and I suddenly said to myself: *I do not want to be an unhealthy fat person standing in the doorway of this beautiful house*. That's when everything really clicked. I'm not struggling anymore. I've lifted the veil. Because when you're wrestling with your weight and not being the person you know you can be, you are living behind a veil. And every person who is buried in fat knows that . . . . So after many years of my weight going up and down—of saying on Monday "I'm going to do it" and by Wednesday failing—I realized that the commitment to do well and to be well is a lifetime of choices that you make daily. The space to live in is not "I'll try." Not "I want to." Not "I really want to." It's "I have decided." I've known all this intellectually for a while, but last year the click came as an emotional and spiritual awakening.[25]

"Unhealthy," "fat" and buried under a "veil" of unwanted flesh, Oprah took charge of her body to uncover the person she knew she could be. Yet, it was not Winfrey's "emotional and spiritual awakening" alone that changed her body: discipline, "mindfulness," self-denial and control were central to her regime, combining exercise and diet with a steely will. Still, from Winfrey's worldview, her new body was achieved through a psychological "self-transformation" as much as it was through hours spent on a treadmill or fat grams passed over.

Oprah's spiritual and emotional shifts enabled her personal transition from the "fat" side of the feminine aesthetic to the "thin" side—or, at least, to a "healthy" reformed body.

Yet, the "Lose Weight with Oprah" boot camp is just the latest in a long line of weight loss plans that are central to Winfrey's ongoing campaign to help women achieve health, fitness, and individual success—for every woman to "live her best life." The February 2005 launch of "Lose Weight with Oprah" was preceded by "The O Health Challenge" in January 2003, which included another personal contract, detailed regimen and nearly two television seasons of expert advice and viewer "follow ups"—all framed through another "boot camp." [26] In 2002, it was "emotional eating" with guest expert Bob Greene.[27] Dr. Phil offered his "get real" weight loss advice in 2001,[28] and the 2000/2001 season was devoted to holistic "lifestyle makeovers."[29] From "carb" addiction[30] to Optifast,[31] an annual cycle of weight loss plans have been queued up to Winfrey's very public struggles with her weight.

These struggles serve a central role in Oprah's carefully cultivated media image. Winfrey's biographic, and autobiographic, self-help narrative draws extensively on the packaging of her weight struggles for public consumption. Eva Illouz suggests that Winfrey's public revelations about her weight establish "diet" as a narrative spectacle, "evolving within the 'real' time of 'real' life," situating the psyche and the body as narrative complications of each other.[32] Through the various cultural sites of Oprah's media empire, this personal connection of psyche and soma is reiteratively rewritten, repeatedly modelling the self-help mantra that

Winfrey espouses and translating it for the television viewer (or magazine reader, or internet surfer, or book buyer). In so doing, "Oprah transforms with great skill an inner dialogue into a public performance aimed at an audience . . . . Oprah rewrites, yet once more, her diet narrative as an inner psychic narrative. Weight loss, a narrative thread through which we can follow the psychic events of her psyche, is in turn translated in commercial ventures performed by a variety of social actors in a variety of cultural media."[33] In postmodern style, the message is recycled and never complete.[34] In just one example, Winfrey's 1996 book *Make the Connection: Ten Steps to a Better Body—and a Better Life* (which she co-authored with her personal trainer Bob Greene)[35] was recast in the "emotional eating" segments of the 2002 season of *The Oprah Winfrey Show*, in "The O Health Challenge" of 2003/2004 and in the various weight loss "boot camps" of recent years.[36] More broadly, this weight loss narrative is resignified with each of Winfrey's audience asides about her weight, each story about "diet" on the cover of *O*, each poll on Oprah.com about women's body image issues. Through such reiteration, Illouz argues that "Oprah subtly invites viewers and guests to imitate her own life, thus creating a powerful charismatic relationship based on the fact that she indeed performs the goods she promises to deliver: namely, the symbolic tools to reform one's life and get better. The therapeutic narrative in which she has cast her biography is thus mobilized to assert a form of charismatic power that is able to create new sources of legitimacy as it performs, induces, and displays the very change it promises."[37]

This narrative reiteration also reflects the necessary stability of Oprah's public identity: Winfrey's weight, in concert with her trademark "confessionalism," acts as a consistently identifiable feature of her public image,[38] paralleling what Jane M. Shattuc calls "Winfrey's steady persona as the conflicted woman."[39] Winfrey's personal "disclosures" about her struggles against racism, her history of abuse and drug use, her troubled childhood, her failed relationships, her wealth, her long time relationship with Stedman Graham and, of course, her weight establish points of recognition with the complex, and often similarly conflicted, lives of her female audience.[40] As Shattuc notes, however, these disclosures are often carefully timed with television "sweeps" and low ratings.[41] Within this multi-media production, each personal disclosure is "part of a skilful balancing act: creating an aura of spontaneity and truth while also maintaining a highly managed image" on which Oprah Winfrey's billion dollar enterprise rests.[42] The resulting stability of this "conflicted" identity, in turn, affects a simultaneous reading of Oprah's public persona and her weight loss discourse.

This persona is also marked by ambivalence and contradictions,[43] however, suggesting, to some accounts, a possible feminist post-structural perspective to Winfrey's therapeutic narrative of self-help.[44] The consistent framing of Oprah's identity, for instance, enables her identification with multiple subjectivities and perspectives; but, to maintain both the stability of her persona and its multiplicitous construction, Winfrey's broad appeal necessarily homogenizes the heterogeneity of her audience. On the one hand, a "systematic defetishization of [Oprah's] persona" enables her appeal through regular deconstructions of her own image, such as her trademark self-deprecating remarks and the regular exposure of her "real" life. Deliberate constructions of personal continuities between herself and guests also bring Oprah "down to earth."[45] As Winfrey reads across individual biographies of race, class, sex, gender, sexuality and nation,[46] her therapeutic narrative and its biographical underpinnings of personal suffering[47]—both Winfrey's own suffering and that of her viewers, audience members and guests—are simultaneously decontextualized and homogenized. This homogenization, in turn, establishes both the "social representativeness" of Winfrey's guests and the "audience as a larger social collectivity."[48]

On the other hand, the Oprah identity appeals precisely because of its multiplicitousness. Deliberately constructed to straddle the line between celebrity and "ordinary," black and white, victim and survivor, failure and success, her persona blurs or, at least, problematizes modernist hierarchical boundaries of separation and difference.[49] Winfrey seamlessly moves between multiple roles, whether host, survivor, student, patient, friend, confidante, advocate or philanthropist. However, she inevitably returns to the words of her guest experts, to her reiterated narrative of self-help, to her own position of authority as "Oprah." The homogenization of Oprah's audience, in other words, is premised on the consistent authority of her own changing voice.

Similarly, while Winfrey's identity is constructed to appeal to a wide audience, it is also built on particularized associations with the African American community and with women. Oprah's own identification with the African

American community informs the worldview that she shares with her viewers and suggests the black feminist perspective that many authors identify as central to her televisual voice. Corrine Squire, for instance, argues that, not only is *The Oprah Winfrey Show* permeated by "race," but it is defined by black feminism, from its production and hiring practices to its consistent challenging of racism, its ongoing problematization of black masculinity and its anti-racist empowerment.[50] Sherryl Wilson notes Winfrey's foregrounding of her "racial" identity, by which Oprah situates herself within the shared African American history of oppression, draws on the rich cultural legacy wrought from this history, and elevates the black feminist grounding of selfhood in women's lived experiences.[51] Oprah's "habitus," as Eva Illouz puts it, applies this accumulated history of African American cultural strategies to the broader contradictions faced by all women.[52]

Winfrey's centring of women's everyday lives, in particular, problematizes the gendered, racialized and power-laden separations between expert knowledge and lived experience, public and private space, personal and political.[53] From this perspective, Wilson suggests that *The Oprah Winfrey Show* is "a heteroglossic form in which the antagonistic clash of both 'official' and 'unofficial' discourses work to produce something new."[54] Furthermore, while talk shows are often decried as a debasement of contemporary social morality, Winfrey's politicization of women's lived experiences instead suggests the positive potential of the (much debated) democratization of the public sphere via talk television.[55] As an exemplar of the feminized confessional culture of talk show television,[56] *The Oprah Show* invokes questions of women's identity, unsettles (at least momentarily) the normative structurings of patriarchal power, and favours process over absolute resolutions. By continually addressing issues of concern to women that are usually relegated to the "domestic sphere," such as marital infidelity, body image and motherhood, Winfrey legitimizes women's voices by validating their "authenticity." [57] Jodi Dean refers to this validation as "the Oprah effect," and suggests that "tabloid journalism and talk shows seem one of the few places where women and, increasingly, men can find a voice. If this is right, then the Oprah effect can . . . provide a forum in which women in particular can find an audience and be heard."[58]

Yet, the grounded female empowerment of Winfrey's "live your best life" campaign is not unproblematic. Squire and others charge, for instance, that Oprah's televisual discourse does little to disrupt heteronormative cultural discourses. Though *Oprah* addresses women's domestic and personal concerns on a regular basis, the underlying socio-historical hegemonies that inform such concerns are rarely interrogated.[59] Regarding the *Oprah* weight loss discourse in particular, Squire notes that "*Oprah's* current emphasis on health and exercise at the expense of diets . . . is undercut by a conventional subtext of the female body as a subject to control . . . and by the frequency with which diets are mentioned, only to be dismissed."[60] Although Winfrey advocates for women's well-being, the daily regimes and disciplinary messages of contemporary femininity are simultaneously reinforced in her weight loss dialogue. The broader sociocultural apparatuses of power/knowledge which infiltrate normative femininity are then not only under-analyzed, they are also reproduced.

Though Winfrey's therapeutic message of self-help superficially seems to belie such messages, the workings of celebrity and business reproduce these hegemonic discourses as well. As Sherryl Wilson notes, "the Oprah persona is highly complex and structured to provide a meaningful point of reference to a 'racially' mixed audience. She embodies a series of conflicting and contradictory cultural formations: the constructions of self that arise from the African American community with which she aligns herself, the culture of anxiety and the therapeutic. These are all bound up with the system of celebrity that operates as a manifestation of the power and mobility of capital in the interests of consumerism and profit."[61] Despite her deliberately constructed personal connection with her audience, and despite her positive advocacy for women's health and well-being, her campaign for women's embodied empowerment remains ambivalent, not only as a mechanism by which Oprah reaches multiple audiences, but also as a substantive feminist response to women's struggles with embodied identity.

Oprah's Clinical Space: Health by Proxy

> Oh, I was feeling so tired and sluggish, and not very happy with myself, and I walked down the aisle [at Wal-Mart], and I saw the O magazine and I saw you looking so fit and I said, "You know, I'm going to do that. I want to look like that."
>
> Guest confessional from *The Oprah Winfrey Show*[62]

As noted earlier, in *The Birth of the Clinic*, Michel Foucault identifies the "clinic" as a moment of exchange—a meeting place—between the doctor and the patient, a spatialization enabled by the convergence of the clinical gaze with the verbalization of symptoms.[63] In line with the postmodern cultural clinic, this clinical exchange is simultaneously magnified and refracted in Oprah's campaign for women's wellness: millions of women displaced by the televisual lens are treated with a homogenous prescription for wellness, thereby producing a televisual clinical space in which the symptomization of weight is treated with the proscriptive of women's embodied self-transformation. Gazing at the television screen, these women see the newly reformed Oprah, connecting her reiterated self-discipline and self-control with holistic "health." They see the "fat woman"; no longer Oprah, the "fat woman" is now the representative guest. They diagnose the confessional symptoms of her personal failure, buried in fat rendered from lack of control and "emotional eating." The disciplinary failure evident in their own self-discipline reflects back in these images, and ensures the objectification of their own "fat" in order to uncover the "real" woman stuck beneath it. In these moments, the clinical gaze merges with the disciplinary impetus of Oprah's multi-media message: the interiorized cinematic gaze of postmodern society,[64] the disciplinary gaze of Foucault's social regulation,[65] and Mulvey's objectifying fetishistic patriarchal gaze[66] come together with the productive/punitive authority of medicine, entwining the multiple sites of Oprah's wellness venture and its multiplicitous participants.[67]

In this televisual clinic, the physician *cum* guest expert does not "treat" the individual woman though. Instead, broad advice is doled out for common symptoms and generic regimes are suggested, with legal caveats tagged on to ensure this homogenized advice is not skewed by the particularities of the individual woman.[68] In this clinical space, the productive and non-reciprocal moment of clinical exchange occurs through the conduit of Oprah herself, at once proxy for a common set of symptoms and exemplar of women's health.

Oprah again plays multiple roles. Most obviously, she acts as the "patient," framing her wellness campaign through her own health issues. To illustrate the risks of women's heart disease, for instance, Winfrey shared the results of her own heart "CT scan" with viewers in October 2005, reviewing her scan on air with Dr. Andrew Rosenson.[69] "Dr. Andy" declared to Oprah, "your heart is perfect."[70] In 2000, she also underwent a "3-D" body scan to urge her viewers to take charge of their health.[71] On *The Oprah Show* and the pages of *O* magazine, she regularly demonstrates her medically supervised exercise regimes[72] and shares the heart healthy recipes concocted by her stable of experts.[73] Revealing that she was experiencing heart palpitations due to the hormonal changes and weight gain of menopause, Oprah also shares her "new approach to eating and exercise" that is the foundation of her "renewed commitment to . . . strength and health"[74]—the foundation, as well, of her self-transformation through weight loss.

Focusing primarily on women's health issues and inevitably tying these issues to weight, Oprah takes on the roles of women's educator and health expert advocate. Winfrey has championed, for instance, the expert advice of Dr. Christiane Northrup on menstruation, pregnancy and menopause.[75] She has promoted the anti-aging advice of Dr. Michael Roizen's book *Real Age: Are You as Young as You Can Be?*, Roy and Lisa Walford's *Anti-Aging Plan*, and Isadore Rosenfeld's *Live Now, Age Later*.[76] Winfrey has also shared Dr. Susan Love and Dr. Judith Reichman's advice on breast health and hormone replacement therapy,[77] and the infertility expertise of Julia Indichova, Dr. Alice Domar and others.[78] Most recently, Winfrey has taken up the cause of women's heart health and weight loss taught in Drs. Mehmet Oz and Michael Roizen's best-seller *You: The Owner's Manual*.[79] With programs such as "Health Mistakes Smart Women Make,"[80] "What the Experts Wish You Knew"[81] and "Outrageous Medical Mistakes,"[82] and *O* magazine articles such as "Let's Get Physical,"[83] "Who's the Boss? How to Ensure You Get A-Plus Medical Care,"[84] and "Ask for What You Want 100 Percent of the Time,"[85] Winfrey advocates women's embodied health through the empowerment of knowledge—that every woman should "know her body."[86] Somewhat paradoxically, though, Winfrey's advocacy of women's health also reinforces the authority of the physician when it comes to health matters, deferring as she often does to the guest expert.[87]

Throughout these programs, Oprah is the exemplar for women's embodied empowerment, serving as a kind of North American "everywoman" and mounting a contemporary passion play five days a week with contemporized morality lessons: eat less (and better), exercise more, be more beautiful; its crucifixion is of "fat America." She becomes a postmodernized invocation of the ideal male model of medicine, identified by Foucault as a grounding concept of modern medical epistemology. As discussed in Chapter 1, Foucault argues that, with its early turn to the social standardization of "health" and "normality," medicine embraced "a knowledge of *healthy man*, that is, a study of *non-sick* man and a definition of the *model man*."[88] Medicine is thus authorized not only to distribute advice on "health," but also on the "physical and moral relations of the individual and the society in which he [sic] lives." With the assimilation and expansion of medical knowledge into social space, Oprah replaces this "model man" with her conflicted, yet stable, black female persona, skewing the terms of this ideal while remaining an iconic figure for millions of women.

Feminist scholars have criticized the ideal male model of medical epistemology, calling out the punitive force rendered from its Enlightenment grounding and consequent hierarchical binarism.[89] This critique potentially suggests that Oprah's skewing of the male medical norm is subversive: she is a powerful black woman outside the legitimized medical establishment who prescribes the appropriate terms for women's health. But, simultaneously, she becomes a proxy of a different sort: proxy for medical authority as she extends the contemporary medical rhetoric of "ownership" of one's health. Her televisual clinical discourse does not question the role that medicine plays in women's lives (a role, at once, positive and suspect). As such, Winfrey's subversive potential is thwarted.

Through her carefully constructed persona, Oprah extends the underlying meaning of this ideal, but masks its disciplinary role through her individualistic campaign for women's well-being. Specifically, as Winfrey's campaign coalesces with her fight against the American obesity epidemic, her personal crusade for women's well-being becomes a "biopolitical strategy."[90] As the exemplar of her own crusade, Oprah epitomizes, in postmodern multiplicitous, technologized form, Foucault's contention that medicine—as a biopolitical strategy—is one aspect of a "productive network that runs through the whole social body," the success of which is the individualization of such instruments of biopower throughout the entire social body.[91] With the location and the parameters of the clinic reiteratively altered, Oprah's weight loss discourse becomes one node in this productive network of social control. And, in her repeated clinical exchange, Oprah exemplifies the individual as the focal point of social medicine—at once treated individually and treated to "cure" social ills. She illustrates the "health" of an appropriately disciplined female body, demonstrating the negotiation between medical authority and individual embodied empowerment in every *Oprah* show on women's health and every weight loss article on the pages of *O* magazine. Oprah's transnational audience and vast cultural resources, in turn, enable the global dissemination of this disciplinary message. That Oprah's televisual clinical discourse is encrusted with the principles of American individualism, contemporary pop psychology and a good dose of consumerism often remains unacknowledged.

Alongside messages of financial stability, spiritual fulfillment and personal achievement, this televisual discourse offers up an extended lesson on the need to lose weight, individualized through the rhetoric of personal transformation. Regardless of the specific weight loss plan or medical advice, a cumulative discourse emerges across these changing regimes that inextricably links women's weight loss with women's "health," whether spiritual health, physical health or emotional health. With Oprah herself held out as the model for loyal viewers to emulate, the thematic multi-media production of Winfrey's "live your best life" campaign produces a proscriptive for living "well," explicitly prescribing a "good" way to live as well as implying its negative alternatives. Winfrey's positive advocacy for women's health inadvertently coalesces with the sociocultural demand that women look and behave a certain way—that they adhere to the disciplinary normalization of the feminine aesthetic. Although Oprah does not directly link the constraining cultural demand for women's thinness with her advocacy for women's health, the disciplinary apparatus of normative femininity is embedded surreptitiously in each program segment on menopause, living as a "fat" woman and strength training.[92]

However, the repeated linkage of women's weight loss with women's health, embodied empowerment and self-transformation masks this disciplinary impetus. Instead, Oprah's weight loss discourse more explicitly reflects the current medicalization of excess weight. Women's weight struggles, for instance, are repeatedly articulated through medical language, at once invoking the legitimized authority of medicine over obesity and reflecting the extent to which medical epistemology is now embedded in the cultural psyche. For example, excess weight is repeatedly constructed as a "symptom of something in your life that needs to be changed."[93] Eating behaviours are medicalized as well. As Oprah declares to one guest, "you ate . . to medicate yourself"[94]; another ate "to anesthetize [her]self from feeling the emptiness, feeling the loneliness, and eating brought comfort."[95] Similarly, a guest struggling with the pain of childhood sexual abuse "used food to numb that pain."[96] In these examples, medicalization explains emotional eating and obesity, giving particular meaning to individual struggles.

The punitive power of medicine is also present in this discourse. *Oprah* guest Jana Lynn Dickson confides, for instance, "I asked my doctor for a copy of my medical records. When I opened the file, the first thing I saw was 'obese female,' and now the word 'obese' is singed on my brain."[97] The sting of this medical objectification prompted her to lose weight. Moreover, Winfrey frequently raises the alarm of the obesity epidemic and the collective shame it brings to Americans. *Oprah*'s "Check Your Health" program begins, for example, with an extended discussion of the American obesity crisis. Oprah notes that 64.5 percent of Americans are obese or overweight, and that heart disease is the number-one killer of women and men.[98] She concludes that "we are so overweight as a country it has become embarrassing. It really is. It's pitiful. Recently, we did a show . . . about what people all around the world think of Americans . . . . They said we're arrogant. We're self centered. We don't even understand our own foreign polices, but what really stood out to me was they all think that we are fat." Oprah then launched her next weight loss campaign to fix this national embarrassment.

Underlining this shame, now both personal and patriotic, each *Oprah* weight loss program begins by interpellating "fat" against the promise of thinness. Oprah's words change, but the message is constant: "you're sick and tired of being fat and unhealthy"[99]; "face your feelings, fight the fat, lose weight"[100]; "there's a resolution inside that says, perhaps, maybe you want to live a better life this year, and for a lot of people, that has to do with taking control of their eating."[101] More pointedly, Oprah also connects the lack of motivation to lose weight with the word "liar": "are you willing to do what it takes to lose the weight? That's what you need to ask yourself so you don't lie to yourself again this year. Because that's the worst thing, is lying to yourself, because then you become a liar and your self knows you're a liar, so then your self don't believe nothin' you say."[102] Referring to her "boot camp" successes, Oprah also highlights the potential of telling oneself the "truth": "they're champions . . . . They're viewers just like you who finally stopped lying to themselves. They took the challenge, created discipline."[103] Women's excess weight is equated, not only with personal failure, but with not being "true" to oneself. And, the hail of "fat" embedded in these lies re-ignites—for Oprah, at least—the disciplinary cycle of diet and exercise that will "cure" the obesity epidemic.

"The *O* Health Challenge," for instance, ran a twelve month series on women's health on *The Oprah Winfrey Show*, in *O: The Oprah Magazine*, and on Oprah.com. Led by *O* Team's Lluminari experts, "a new collaborative of women's health leaders,"[104] the Challenge addressed women's health issues and scheduled goals for every aspect of women's well-being, from health planning, self-assessment and aging to workplace health and sexuality.[105] The series culminated in an *Oprah Show* program of weight loss success stories, weight loss again signifying the healthful transformations of Oprah's viewers. Despite Oprah's claim that the numbers don't matter,[106] these numbers spoke, quantifying the transformations of Oprah's guests: "16 dress sizes, 115 pounds gone"[107]; "I've lost 60 pounds, and I feel wonderful[108]"; "I've lost 35 pounds, and I feel great"[109]; "20 pounds"[110]; "75 pounds"[111]; and, "Size 2! It's 0 from there."[112]

Such significations extend Winfrey's symptomatology of weight to an interrogation of the psyche. The curative is not a drug or a pill.[113] Instead, the discipline of facing one's emotional problems and doing the hard work of losing weight is key. With the 2005 *Oprah* boot camp, the prescription was: exercise eight times per week, "eliminate the white stuff," stop eating three hours before bedtime, and eat only for sustenance.[114] With Bob Greene's *Total Body Makeover* (upon which Oprah based her "boot camps"), it was the "five simple rules" of eating, coupled with a twelve week program of strength training (including nineteen exercises for three ability levels), "functional fitness" (including fifteen exercises for three ability levels), aerobic exercise, and "double aerobic" exercise.[115] Winfrey and Greene's *Make the Connection* prescribed "10 steps to a better you," including: five to seven days per week of (preferably morning) exercise, at a prescribed intensity and for a prescribed length; a low-fat, balanced diet of three meals and two snacks daily, two servings of fruit and three servings of vegetables daily; six to eight glasses of water daily; little or no alcohol; and, no food for three hours before bedtime.[116] Whichever regime is highlighted, Oprah's televisual clinical space promises that the daily practices of self-awareness, self-control and self-discipline will produce a transformation, revealing the new "you"—a healthier, slimmer, more authentic "you"—curing the collective shame of the American people with each "rep," each fat gram counted, each plate of "white stuff" passed over.

Re/forming the Fat/Thin Binary

I am most interested in the message of normative feminine embodiment that is created in this televisual clinical space. Alongside food plans and exercise regimes, Winfrey's individualistic campaign for women's well-being reproduces the loaded cultural binary of "fat" versus "thin." Though *The Oprah Winfrey Show* addresses obesity in a significantly more measured and thoughtful manner than most talk show television, "fat" is still explicitly coded as unhealthy and personally limiting, as well as unattractive. Program material designed to elicit empathy for women's experiences of "fatness," for instance, is muted by Oprah's fervent efforts to "fix" the American obesity epidemic. The obvious solution to this crisis is weight loss; and, its resultant "thinness" is alternatively constructed as a reflection of "health," an expression of one's true self and an opportunity for a fuller life. Each of these constructions link women's transformed identities to their self-discipline, self-control and "mindfulness."

Despite Oprah's advocacy for women's individual empowerment, the *Oprah* weight loss discourse reinforces the cultural paradox of obesity: obesity is the North American norm, but thinness is idealized as "normal."[117] The thousands of *Oprah* guests and viewers who reiterate the terms of Winfrey's weight loss campaigns—in their contracts posted on the fridge, their letters to Oprah, their guest confessionals, their adulation of Winfrey's new trim figure—also inadvertently reproduce the cultural denigration of obesity. While countering the cultural impetus for feminized thinness with a rhetoric of health and spiritual fulfillment, Winfrey's weight loss discourse does not substantively challenge the social aestheticization of weight that aligns "fat" and "ugly" against "thin" and "beautiful." Winfrey's campaign gives greater symbolism to obesity and acknowledges the emotional pain it elicits; but, its production of "fat" experience still stigmatizes the experience of being overweight, albeit in a supposedly more compassionate way. Moreover, Oprah's weight loss discourse is premised on establishing obesity as a multiply negative experience, exposing its negative emotional grounding as the precursor to self-transformation in order to overwrite it with the "authenticity" of a newly reformed thin and healthy body. On the one hand, weight loss signifies successful self-transformation. On the other hand, "weight," whether labelled as "fat," "obese" or "overweight," is signified, through absence and negativity, as something to overcome. Revealing the contradictions and slippages of this discourse, these significations signal a discursive inversion in which "fat" bodies become "less than" Oprah's reformed thin ideal; and, the reformed thin body denotes becoming "more of who you are."[118] Invoking the cultural valorization of thinness, more bodily space is aligned with less positive value; and, less bodily space is aligned with greater worth in the reiterative production of Oprah's televisual clinical space.

Producing "Fat" Experience

Through viewer and guest confessionals, several themes emerge in the *Oprah* production of "fat" experience that construct the personal experience of obesity as lacking and wrought with negative emotion, exposing as well the contradictions and slippages of this production. First, Oprah's public persona is built, in part, on the simultaneous reading of her persona and her reiterative narrative of weight loss, as I discuss above. Yet, Oprah herself plays a secondary role in recent *Oprah Show* programming on "fat" experience. Winfrey regularly interjects to share her own experiences, thereby aligning herself again with her audience, but the emotionally charged stories of "fat" experience are those of her guests. Oprah now shares intimate details of her food plans, exercise regimes and personal health care choices, and even refers to past traumas, but she does not expand on the deep emotional pain of her own "fat" experience. This distancing simultaneously situates Oprah as "reformed"—she's already been there, as she often tells her audience—and reiterates her weight loss narrative through the words of her guests.

The voice of fat experience is represented disproportionately by individuals who are or, more frequently, once were severely obese. *Oprah*'s treatment of fat experience is almost exclusively constructed through their weight loss narratives. "Fatness" as an experience in itself or from a positive perspective is given little room. While *Oprah* has aired a few episodes dedicated to the experience of being "fat" in the past five years,[119] dozens of programs on weight loss address personal experiences with obesity. Extending the reiterative narrative of Winfrey's weight loss dialogue, these weight loss programs repeatedly read fat experience through the pattern of "before" and "after," with "fat" remaining in the "before" frame—no "failures" find their way to Oprah's stage. Distancing obesity from Oprah's campaign for women's self-transformation, the "before" image is invariably projected, larger than life, on a studio screen. The audience gazes with Oprah at the flat image of a fat body. Extending this televisual displacement, the viewer at home gazes through the television lens. "After" is represented by the reformed—thinner, healthier, happier—individual who walks on stage to be congratulated by Oprah. These reformed individuals speak about the struggles of "fat" experience, but only after these struggles have been overcome. On the one hand, these weight loss programs give voice to the often painful experiences of obesity—hearing them, validating them, sympathizing with them. On the other hand, the reiterated structure of before/after overwrites each negative tale of obesity with a life-affirming message of self-transformation.

This production of "fat" experience is signified by lack, marking it with further discursive displacement. Individuals share their health problems and routinely state that they are "unhealthy." For example, they fear *for* their health and "health" is articulated as something they have lost and must "get back": "the only thing I cared about was just . . . getting healthy"[120];"I've kind of put my health on a back burner."[121] Routinely, "fat" is objectified and disembodied, as with Oprah's frequent tag for her weight loss campaigns: "fight your fat, lose weight."[122] Guests disembody their "fat" as well, and disassociate themselves in turn from their bodies. As one guest states, "I remember looking at my body, thinking, 'This has to go.'"[123] At times, this kind of disassociation erupts as embodied alienation: "I relate most to transgendered people because I always felt that I was stuck in a [fat] body."[124] This kind of language is common enough, but its repetition ironically signifies a larger body as "lacking"—lacking health and lacking cohesive embodiment.

A curious slippage around gender is also produced in the *Oprah* production of fat experience. Despite Oprah's largely female audience and the intensely feminized struggles with weight in contemporary culture, the gendered nature of fat experience is often under-addressed. While gendered issues such as sexual abuse and troubled relationships are often associated with eating practices by Oprah's guests, the absence of normative gendered experiences frequently signifies "fat" experience: lack of sex, relationships, attention and beauty each signify the cultural absencing of obesity from "normal" experience. Interestingly, Oprah's male guests most often, or at least most vehemently, express this lack of "appropriate" gender roles and behaviours.[125] Women also express concerns over relationships, attractiveness and desirability, but many—though not all—female *Oprah* weight loss guests are married (or partnered) mothers. That male guests frequently represent the most severe examples of obesity on *The Oprah Show*, and consistently express a desire for "normal" relationships, reflects an additional slippage in this gendered production of "fat." Specifically, the isolation and passivity of male obesity is constructed as a negatively coded "feminization" of men's identities; in turn, weight loss becomes the means by which to regain "masculinity" or "virility."[126] That these absences and slippages may precisely mark the gendering of obesity in contemporary culture remains under explored, at least from a broader sociocultural or feminist perspective. However, if "fat" in this context is marked by absence and lack (whether the absencing of women from normative female experiences or the feminization of men entirely), this logic implies that "thin" is unproblematic, or at least that thin is normatively gendered and experienced. Yet, the struggles of numerous women, including those represented in my other case studies, suggest that "thin" embodiment is far from untroubled.

Still, the narratives of fat experience on *Oprah* feed Winfrey's weight loss dialogue by providing a cautionary example that reinforces the hegemonic "health" of thinness by productively prohibiting obesity. Obesity is positioned in direct contrast to the campaign for women's wellness; and, the "loser" is signified as more "mindful" and more self-aware. Yet, in the *Oprah* treatment of "fatness," it becomes clear that none of Oprah's obese, or formerly obese, guests are less mindful of their weight or bodies than their non-obese counterparts. In fact, they speak of feeling trapped in their bodies, constantly reminded of their extra weight and repeatedly stigmatized, both by those around them and by themselves, turning the negative cultural connotations of "fat" on themselves. Within the absences of obesity, intense negative experiences fill the void.

Derogatory comments, for instance, plague Winfrey's overweight guests, reproducing the cultural derision toward obesity while also illustrating it. "Jelly legs" rings in the ears of one guest.[127] For others, numerous insults stand out: "they just started calling me porky. Every fat nickname you could think of, I got hit with. We could show a movie on your ass. Even adults would stare at me and point"[128]; "they used to call me all kinds of names. 'Fatty, fatty, two-by-four, can't fit through the kitchen door'."[129] For yet another, a stigmatizing experience remains: "when I was in elementary school, a teacher had me come to the front of class and weighed me in front of everyone and it was just terrible."[130] One exchange, video-excerpted from the documentary *The Size of It*, illustrates this stigmatization perhaps more subtly but also on a more intensely personal level. The excerpt reveals how the tension between *Oprah* guest Lisa Brounstein and her mother, Gayle Wise, hinges on the public stigma of obesity. Despite Brounstein's positive self-image, both she and her mother acknowledge the power of this stigmatization:

> *Lisa Brounstein* (daughter): . . . No matter what I do, no matter how great I do, there's still this level of disapproval and discomfort and upset around the fact that I'm fat. You would tell me I'm beautiful, and I didn't believe you. And now as I'm older, I can look at myself and I look at my body and I think I have a pretty cool body. It's very—it's interesting, it's different, it's fun. It's like art. And you think it's ugly. That's hard.

Gayle Wise (mother): The words are just amazing. Ugly and disgust. No, no, I mean, they're your words. That's how you feel.

Lisa Brounstein: That's what I feel. That's my perception.

Gayle Wise: That's just really interesting that I am putting that out to you. It is painful for me when I watch other people look at her and I want to say to them you don't know her. We live in a world and Lisa knows this where we are all judged on our appearances. And as shallow as that is, it is a fact of life.[131]

Oprah's guests are troubled and ashamed by such experiences, but they also construct their obesity as "abnormal" and "unattractive" themselves. Some simply say, "I felt fat. I felt ugly."[132] Others speak of their "fat" as a "thing" with which they must contend: "I didn't feel comfortable with it. I just felt that one day I'm going to be normal."[133] Graphically illustrating the "ugliness" of obesity, one severely obese guest shares, "it's embarrassing, but, you know, how a normal person would put deodorant on just underneath the armpits? I actually had to put deodorant in the rolls, the folds of the skin because it would become odorous."[134] Another reveals, "I must shave my face because my hormones are so screwed up that if I didn't shave, I would have a beard. And if I have to go to the bathroom, it's sad to say, but I can't take care of cleaning myself."[135] The carnival grotesque of talk television is at work in these spectacular examples, invoking the "circus freak" as fat woman.[136]

For many of Winfrey's guests, the shame of obesity is closely associated with social and physical isolation. Lora Toovis, for example, describes her self-imposed isolation when diagnosed as morbidly obese: "I isolated myself from everyone but my immediate family. I stopped going out. I became a vegetable in my own home."[137] Eleven year old Mike Holtz says of being 200 pounds, with symptoms of diabetes and depression, "most of the time I really feel like I just want to be in the house 'cause I don't have anybody to play with . . . . It scares me that I feel like I'm going to be 400 pounds when I get older. When I look in the mirror, I think to myself, 'I'll never get a girlfriend. There's probably no girls that like me anyways.'"[138] Connecting his overweight body with his painful feelings, Winfrey states of Mike, "at night, he would cry in his mother's [arms] praying for a different body."[139] Similarly, Winfrey introduces long-time recurring guest Stacey Halprin, a formerly morbidly obese New York City woman whose story *Oprah* has followed for over a decade, by reminding viewers that "she was no longer able to walk or to stand. She became a prisoner in her own home."[140] Halprin picks up this narrative thread to describe how her isolation came to a breaking point with the bombing of the "twin towers" on September 11, 2001: "I live a mile from ground zero. They closed off all the blocks from 14th Street below and I'm below. In order for me to get the basic necessities of what I needed, I would have had to have gone a quarter of a block and I couldn't."[141] She continues, "I never wanted to do a gastric bypass up to the point of 9/11. I just didn't want to do it . . . . then 9/11 came and I couldn't get to the corner to get anything I needed, and I realized even though everyone else knew because I was carrying around a chair and a cart instead of admitting I needed a wheelchair, that I was immobile and that was my bottom, being immobile."[142]

This connection between isolation, being overweight and negative emotion goes further for some guests. Cindy Homan, a guest on one of *Oprah*'s "Incredible Weight Loss Stories," shares her desperation: "as I put on weight, I isolated myself and I stopped participating in life. Instead, I spent countless hours sleeping on the couch and eating everything in sight. Before I knew it, I was 50 pounds heavier, miserable and even contemplated ending it all."[143] Rick Salewske mirrors this despondency: "As I gained more and more weight, I got more and more isolated. And I got more and more depressed. And I ate more and more . . . . Because of my weight I had given up hope of having a serious relationship with a girl, let alone getting married to a girl or having kids. I was so embarrassed to show anybody any part of my body. I got to a point where I started, you know, not caring. And I actually told a buddy of mine, 'What if I died? It's OK if I died.'"[144] And, Peter Herida, a man bedridden by his weight, bluntly states, "I just gave up. I—I didn't want to do it anymore. I thought many a times of ending it all, ending my life. I knew I could never lose this weight. I—I just saw myself falling further and further into the hole . . . . I looked for a way of—of going to sleep, not waking up."[145] In these *Oprah* confessionals, being "fat" equates with a loss of the will to live. Returning to an earlier point, men's narratives serve again as particularly revealing or extreme examples of the negative emotional consequences of obesity. They reveal a similar disciplinary impetus in men's and women's embodied struggles, but also expose the slippage between masculinity, femininity, obesity and control. In these confessionals, the "out of control" obese male body is articulated in a distinctly feminized public space—the television talk show.

These multiple significations of "fat" are repeatedly linked with issues of control as well. While Oprah's weight loss discourse conventionally frames obesity through a lack of "control," guests' descriptions are more varied. Many women directly label their lack of control: "I kept gaining weight and I'd feel more and more depressed. I had thoughts of committing suicide. Things were completely out of control"[146]; "I just felt lost. I was feeling so out of control with my life in general . . ."[147] Other women describe their eating practices and imply a loss of control: "I order enough food for three people. I just eat and eat and eat"[148]; "I do six cookies at a time because, you know, it's only [six] cookies, but next thing I know I've eaten the whole thing of cookies. It's gotten to the point where I don't even realize what I'm doing."[149] Intimating feminist theories about weight issues, guest Erin Smith describes her "emotional eating" as caught up with both the loss and maintenance of control: "triggers that set me to eat are stress, control—when I feel like I am losing control of a situation and that the only thing that I can control is, you know, what's coming into my mouth."[150] Similarly, Lora Toovis states, "I was going to get control over the food other than having the food maintain the control over me."[151] Control is complexly connected with these experiences of being overweight. And, contrary to Oprah's argument that "mindfulness," self-control and self-awareness must be "found" in order to lose weight, the "fat" experiences of Winfrey's guests demonstrate that these characteristics are deeply embedded in their struggles with obesity; they are just not the "transformative" characteristics of Winfrey's weight loss regime.

Making the Connection

The extensive detailing of fat experience on *Oprah* establishes the basis for Winfrey's weight loss discourse. Oprah's guests uniformly associate their weight with emotional pain, but this discourse hinges more precisely on the underlying trauma that precedes or coincides with obesity. In their book *Make the Connection*, for instance, Winfrey and Bob Greene identify overeating as "the most socially acceptable coping mechanism" for dealing with emotional traumas[152] that "generally come from childhood experiences or traumatic events."[153] For Winfrey and Greene, whether in their co-authored books or the numerous *Oprah Show* segments based on their shared philosophy, such unresolved traumas lead to a lack of self-worth or self-esteem. Attaching psycho-medical rhetoric to physical weight and psychic trauma, weight in turn becomes "a symptom of something in your life that needs to change."[154] Winfrey frames this "something else" as an issue of individual spirituality. The following exchange between Winfrey and "weight loss success" Julie illustrates this connection:

> *Winfrey*: When the weight is the symptom of everything else that's wrong, it's not about the food.
>
> *Julie*: But I never did the internal work, I never dealt with issues that were keeping me that size. So I kept putting it right back on.
>
> *Winfrey*: And, you, I say to people until you're do—until you're willing to do that work…

Julie: Right.

Winfrey: …you will just continue to pay the price and become—the cycle continues.

Julie: That's the sad part.

Winfrey: It's—it's—you know what it is? What's amazing about it, it's the real spiritual work of your life. It is the most…

Julie: That is so true.

Winfrey: It is the most holy, the most spiritual thing you can ever do for yourself.[155]

Reading against this spiritualized perspective, "fat" is unholy, unaware, unfulfilled, again signified by absence. Paradoxically, excess weight is then positioned as a barrier to self-fulfillment, strangely reified as "some thing" that exists beyond the individual, masking the true person hidden inside. Oprah's own "veil" of unwanted flesh, behind which she was caught, is mirrored by her guests. Pop star Carnie Wilson describes her "fat" as "those layers of protection" with which she "was covering up [her] feelings"[156]; and, Oprah staffer Lisa Erspamer says, "I wore a suit of pain; 90 pounds on my body, 10 tons on my heart . . . . I'd let the food and fat enfold me again."[157] One "emotional eating" guest shares, "I realized that my weight was a mask. All my life, I had felt virtually invisible."[158] Another expands this metaphor: "my weight is my armor, my shield against being looked at or—or, you know, whatever my issues are."[159] The "real" individual is hidden inside the "fat."

Furthermore, Winfrey's framing of weight as a barrier to self, or alternatively as a protective mask, closely parallels many contemporary pop psychology perspectives on weight loss. It is strikingly reminiscent of Susie Orbach's ground-breaking, second-wave feminist work *Fat is a Feminist Issue: A Self-Help Guide for Compulsive Eaters*.[160] Although I do not intend an extensive comparison of the two approaches, I want to highlight a number of overlaps, and key differences, between Orbach's interpretation of women's experiences with fatness and Winfrey's. Published nearly two decades before Winfrey and Greene's *Make the Connection*, Orbach's book and its companion text of psychological exercises[161] distinctly connect women's compulsive eating practices with women's politicized identities. Developed out of feminist self-help groups, which themselves developed through the consciousness raising experiences of the women's liberation movement, Orbach's feminist therapeutic approach was one of the first to interpret women's eating habits as coping mechanisms, suggesting that women's experiences with "fat" were not about food.[162] Winfrey also frames overeating as a coping mechanism, stating that "eating can be a coping mechanism that allows you to avoid the resolution of emotional issues that negatively affect your life. The issues need to be addressed, not just the eating."[163] Winfrey's construction of fat as a psychic barrier parallels Orbach's discussion of women's boundaries. While Oprah and her guests describe fat as a "veil," "mask" or "layer," repeatedly situating fat as a barrier to self-fulfillment, Orbach identifies a woman's fat as a "physical protection against her believed vulnerability. She imagines that if she loses the weight she will be losing a protective coating against the world."[164] However, Orbach interprets this protection more positively than does Winfrey, who constitutes fat as a "veil" of unwanted flesh. For Orbach, fat provides space and protection, removes women from the need to compete, and simultaneously dulls difficult emotions while providing a familiar concern around which to focus energy.[165]

Winfrey also takes up two strategies proposed by Orbach and now common in pop psychology. Orbach suggests keeping a diary or journal to note reactions and insights, and to track emotional progress, not primarily food intake[166]; Winfrey also identifies journaling as a strategy, but one that will lead to "mindfulness" by tracking emotional responses to food, food consumed, exercise completed, and goals adhered to.[167] Both approaches suggest "relearning" the sensation of hunger that has often been ignored or lost through overeating.[168] For Winfrey, the goal is to eat less through this renewed "mindfulness." Rather than weight loss, though, Orbach identifies breaking the addictive relationship with food and becoming more comfortable with food as the primary goals.[169]

While Orbach identifies the isolation, personal invalidation and emotional pain of which Oprah's guests speak,[170] their approaches fundamentally diverge on the underlying cause of "fat." Orbach conceives fatness as an embodied response to sexual oppression. She writes that "getting fat . . . . [is] a definite and purposeful act; it is a directed, conscious or unconscious, challenge to sex-role stereotyping and culturally defined experiences of womanhood. Fat is a social disease, and fat is a feminist issue. Fat is *not* about lack of self-control or lack of will power. It is about protection, sex, nurturance, strength, boundaries, mothering, substance, assertion and rage."[171] Winfrey's weight loss discourse does not make this connection. While it does connect women's emotional traumas to their weight struggles, these struggles are not situated substantively in either the context of women's oppression or in any broader sociocultural context. In Oprah's weight loss discourse, "fat" remains a symptom of individual emotional pain and an individual responsibility, reiterating the standard cultural interpretation of obesity. This individual responsibility requires self-control, self-discipline and "will power" in order to overcome the fatty barrier to self-fulfillment.

Yet, Orbach's perspective retains the residue of its time. While fat *is* a feminist issue, Orbach's approach potentially essentializes women's fat experiences and offers an individualized solution to a socially rooted problem. If women's weight issues reflect the social constraints of womanhood, should the solution be to modify women's bodies further, albeit with a different kind of regime? This is not to say that women should not address or acknowledge the gendered meanings of their weight, but rather to highlight that any means of bodily control may become fraught territory for women. Further, while Orbach identifies key issues with which women struggle, her approach still tinges fat with a negative connotation: it represents the pain of women's daily lives. Where, for instance, would the contemporary movements of fat activism or fat pride fit within her construction of excess weight as predominantly a protective mechanism? Despite such concerns, Orbach's work still stands apart from

Winfrey's in its articulation of fat as politicized, whereas Winfrey consistently reiterates more hegemonic connections between fat and identity.

A recent *Oprah* episode, entitled "Have You Let Yourself Go?," provides a most telling example of this connection between "fat" as a symptom of low self-worth, a signifier of trauma and a mask of one's true self. This episode highlights the peculiar gendering of weight issues on *Oprah* in the absence of their sociocultural context. "Have You Let Yourself Go?" is not one of the many *Oprah* "weight loss" programs. Instead, Oprah introduces it as the start of an ongoing series on "launching your own comeback." Four female viewers are profiled, for whom personal traumas and life changes have led them to "let themselves go." For each of these women—and for the numerous viewers whose video "confessionals" are interspersed throughout the program—fat has become a signifier of their struggles with failed relationships, sexual and emotional abuse, and the overwhelming experiences of motherhood. Gaining weight aligns with losing control of their lives. The women are asked, in turn, to look at pictures of themselves projected on a screen in the *Oprah* studio. Of her larger than life image, Julianne says, "It looks like I'm in a fat suit. I've got little things that jiggle in behind . . . . and I feel like I've got an extra person carrying on the backside"[172]; Andrea Smith reflects, "I see a fat unhappy woman that nobody would look twice at. I see a woman who is embarrassed to be in her body. I see regret."[173] Similarly, Nathalie Ames says, "[my weight] has become my shield. I feel—I have such fear of being hurt again that I have gained this weight. It is my protective wall."[174] Oprah makes the connection this way: "We're talking about one of my favourite subjects in life: Have you let yourself go? Pull out a picture of yourself from 10 to 15 years ago. Do you recognize that person? Thirty-five percent of the women that we polled on oprah.com say that they've gained over 50 pounds since getting married. Thirty-five percent. But today is a new day, and it is time, I believe, for us to pull ourselves back together."[175] Distanced from their own fat projections, these women no longer "recognize" themselves. They see, instead, a "fat suit," an "extra person," "regret" and a "protective wall," again symbolically separating the "fat" from the individual in order to reveal the real woman who lies beneath—in order to launch her own comeback.

Unveiling the Re/formed Body

Lying in the chair at my aesthetician's (at another vanity induced escape), the women start talking about Oprah. It's five o-clock, the time Oprah comes on in my town, right before the six o'clock news. I can hear Oprah address her audience in the background, but the topic of today's show is barely acknowledged in the salon. Oprah's weight, how she's kept it off, how gorgeous she is—now—are what the ladies want to discuss. In this moment, Oprah emerges again as the exemplar of her own weight loss discourse—now thin and gorgeous, exuding the success of self-transformation to her viewers. Most important to this transformation is its invocation of her "new," thinner body as a newly "re/formed" body: a body re-formed to thinness that has the power to overwrite the "fat" body it once was. Unveiled from behind a barrier of fat, this body exemplifies the spiritual and emotional transformation wrought from self-discipline and self-control. Once unveiled, psyche and soma emerge renewed, transformed, enabling a new life. Again, Oprah's guests reiterate this message. For one guest, weight loss allowed her "to be the person that I thought I was all along."[176] Weight loss helped another to uncover "my new life, the real me."[177] For yet another, it means "my life is complete."[178]

In a subtle shift in meaning, others are metamorphosized. "R&B" singer Kelly Price describes her 100 pound weight loss as "a complete metamorphosis. I was like a caterpillar that went into a cocoon and, hopefully, I came out a butterfly."[179] Fifty-year old weight loss success guest Ginny Pollard is described in the following way by a friend: "she is metamorphosized into this beautiful butterfly that wants to wear clothes that seventeen-year-olds wear."[180] No longer the obese, fifty-year old housewife, the transformed Ginny is now thin, beautiful and acting like a teenager. Expanding the analogy of fat as a veil that must be lifted, the metamorphoses of Oprah's guests suggest a fundamental change in character.[181] Weight loss is not simply an uncovering of the "real" individual. Rather, a new individual emerges from beneath the "fat"—re/formed from the "fat" that has melted away.

Given the pain and negativity with which "fat" experience is signified on *Oprah* and throughout popular culture, it is no surprise that a new "you" is what Oprah's guests want. These metamorphoses thus mark another slippery absencing of "fat" in Oprah's weight loss discourse. The repeated stories of "fat" experience set up the moments in which metamorphosis is possible. Oprah's viewers must recognize these "fat" experiences to initiate their own transformations; they must see themselves in the "before" shot to desire the "after." The slippery trope of this recognition is that its familiarity is firmly erased once the re/formed body is achieved. Though psyche and soma merge in the Oprah's weighted transformations—the re/formed body revealing the new "self"—metamorphosis ostensibly disconnects this "fat" recognition.

However, to maintain this particular separation of the new psyche from the fat soma, the re/formed body must be continually rewritten—resignified—with the daily practices of Winfrey's campaign for women's wellness, whether through the "boot camp" rules, the exercise regimes or the various other prescriptives of Oprah's clinical discourse. These technologies of the self, these micro-physics of power reproduce the re/formed body with each "rep," each fat gram passed over, each mile clocked on the treadmill. Each of these disciplines, in turn, signifies the re/formed body by its exclusion of the "fat" soma, thereby rewriting the transformative narrative of Oprah's weight loss discourse. Magnified and multiplied by her viewers and guests, this reiteration re-entrenches the legitimacy of Winfrey's campaign for women's wellness.

Read through Oprah's own body and the bodies of her weight loss success guests, this narrative also exposes the point at which Oprah's ongoing narrative of individualistic spiritual empowerment falls apart. Each metamorphosis celebrated on *Oprah* signifies a moment in which weight loss collides with the thin feminine aesthetic, and the line between "health" and conformity blurs. And, because this discourse is only produced through its continual reproduction, its terms must be continually retraced, thereby necessitating the multiple *Oprah Show* programs on weight loss success. The normative boundaries of its renewed feminine aesthetic are marked out only with each celebration of success. Each success is itself then marked by exclusion, the "fat" body again (and again) becoming "less than" its thin replacement.

This articulation of the feminine aesthetic as the re/formed body initially elides the cultural baggage attached to the thin feminine ideal: in Oprah's weight loss discourse, the focus is physical, spiritual and emotional "health," not necessarily "beauty." Yet, the re/formed body both merges and aestheticizes health, weight loss and women's bodily discipline, establishing its renewed feminine ideal as more beautiful, more vital, more "healthy." This layering of health onto the thin aesthetic reflects a broader cultural referent in which the regulatory regimes of health and feminine aesthetics converge. Winfrey's iconic pop culture status thereby enables the transmutation of the thin aesthetic under the guise of "health," and intensifies its disciplinary impetus. Illustrating Foucault's concept of disciplinary normalization,[182] this re/formed ideal implies that the self-control and daily discipline required by Oprah's "boot camps," her personal contracts, her regimes of exercise and good eating will not only re/form your body and enlighten your "spirit," but also make you more "acceptable" in the social world. Winfrey's campaign for women's well-being is but the latest panoptic disciplinary mechanism enabling the "health" of the social body. Whether to sell magazines, boost television ratings or genuinely help women, the discourse of Winfrey's multi-media clinical space captures a hard social "truth": being a thin woman—and especially no longer being a fat one—holds particular value in contemporary culture.

Again, the dialogue of *The Oprah Show* spells out this "truth" but simultaneously reveals the contradictions of Oprah's re/formed body. First, although Oprah frequently decries the cultural demand that women should look a certain way, her rhetoric of self-transformation through weight loss firmly entrenches the idealization of feminine thinness. Weight loss, for instance, "is about being the size that's right for you"[183]—"don't strive for perfection,"[184] Oprah tells viewers. But, thinness is continually identified as the "thing" that Winfrey's weight loss guests want. As guest Stacey Halprin said before her dramatic weight loss, "I want to get thin more than anything in the world."[185] Though Oprah asserts that "I don't do it to lose the weight. I do it to keep myself feeling more fit,"[186] she also declares that it is about stepping on the scale and "owning the number."[187] Numbers again solidify this connection of health, weight loss and the thin feminine ideal. Statements such as "together we've lost over 30,000 pounds"[188] and "boot campers . . . lost over a million pounds"[189] validate the success of Winfrey's weight loss campaigns. Other numbers signify the transformation of Oprah's guests: "twenty-five pounds of fat"[190]; "she lost 127 pounds."[191] "305 pounds"[192]; "242 pounds without surgery"[193]; "you lost two whole people."[194] Numbers also reveal the discipline associated with the re/formed body: "Dana's weight now: 134 pounds. Her dress size: four. Her diet: no more chocolate; low-fat foods, fruits, vegetables, soups and lean meats. Her workout: ninety minutes of cardio every single day."[195] Oprah's own numbers cement her carefully constructed status as a contemporary "everywoman": "I do at least 300 sit-ups a day"[196]; "my team . . . hits the gym eight times a week"[197]; "33 pounds gone."[198] In the gruelling regimes that produced (and reproduce) her new look, Oprah does 45 minutes of aerobic exercise six days a week, goes for a 75-minute run once a week, does a 20-minute workout four to five evenings a week, and strength trains four to five times a week with, depending on the day, three sets of ten repetitions of seventeen different exercises.[199] These numbers quantify the technologies of the self required to absent the "fat," counting out the endless discipline required to "become more of who you are."

With this focus on weight loss and discipline, "beauty" might become a by-product. However, the dialogue of weight loss on *Oprah* regularly unmasks the insinuation of aesthetics into these practices of "health." Along with its repeated quantification, the re/formed body is repeatedly connected with beauty and hetero-desirability. In one instance, Oprah remarks on the appearance of weight loss success guest Elizabeth: "[she] has one fabulous body. She's a hot babe,"[200] Oprah marvels, "you go from being a hundred pounds overweight to being ripped. That's really, like, a whole 'nother life. I mean people look at you differently, respond differently."[201] While such examples are practically endless on *Oprah*, a "surprise" that Oprah arranges for weight loss success guest Tasha highlights the connection of thinness, beauty and desirability. Interior design celebrity and current sex symbol Ty Pennington celebrates Tasha's new, thin look with Oprah, presenting Tasha with a butterfly-embossed gift box—"since you're going into a metamorphosis." Pennington gushes to Tasha, "you're looking pretty smokin'. You look hot . . . . I made you a little matching necklace . . . that you can totally put around your gorgeous little neck."[202] Tasha's re/formed body now warrants both male attention and gifts that fit around her "gorgeous little neck."

A broader, implicit message comes through this exchange: an appropriately controlled and disciplined female body, one appropriately re/formed to thinness, will be rewarded. In Oprah's weight loss discourse, these rewards are overtly framed in terms of "health"—physical, spiritual and emotional. That attractiveness and attention come along with the discipline of weight loss seems to be a secondary, though much lauded, point. Not only is the feminine bodily ideal re/formed in Oprah's weight loss discourse, its rhetoric is resignified to make the thin aesthetic more palatable as well. This re/formed feminine ideal still resonates with the cultural idealization of feminine thinness, but it is now read through a veil of "health" and individual empowerment. As noted earlier, Corrine Squire suggests that "*Oprah's* current emphasis on health and exercise at the expense of diets . . . is undercut by a conventional subtext of the female body as a subject to control . . . and by the frequency with which diets are mentioned, only to be dismissed."[203]

Illustrating Squire's point, Oprah says, "diets just don't work. You must design your own food and fitness plan if you want to succeed."[204] Her recent weight loss "boot camps" have, therefore, promoted customized food and exercise plans,[205] ironically alongside Winfrey's boot camp "rules" for exercise, eating and self-discipline. While it is not then about "diets" per se, her campaign for women's wellness is constructed with multiple, often conflicting, demands. It is about health: "if you concentrate on your health, you can never go wrong."[206] It is about discipline: Oprah urges viewers to join her weight loss success guests who "took the challenge, created discipline."[207] It is about emotion: "you will never solve your problem of weight with a diet if you are an emotional eater. A diet is not going to solve the problem. You have to fix the emotions."[208]

Though Oprah dismisses "diets," articles on "diet" and weight loss grace the pages of nearly every recent issue of *O: The Oprah Magazine*. *O* does offer a "non-diet diet,"[209] but cover stories such as "the 'Yes, I can!' Diet,"[210] "Why Weight Watchers Still Works,"[211] "Diet Doctors' Diet Secrets,"[212] "Three Crash Diets—Doctor Approved!,"[213] "Twenty Diet Tactics,"[214] and "The All-Day-Energy Diet"[215] promise weight loss success. Similarly, *O* warns of the dangers of diet pills[216] but celebrates the "next generation" of weight loss drugs at the same time.[217] And, beyond the *O* issues and articles dedicated to Oprah's weight loss campaigns and her new shape,[218] numerous articles tackle weight loss, from "systems" such as Dr. Phil's "Ultimate Weight Solution"[219] and "The Buddy System: Lose Weight Together"[220] to individual articles such as "Have You Hit the Weight-Loss Wall?,"[221] "Keep It Off—Forever! Ten Rules of Permanent Weight Loss"[222] and "Weight – Why It's so Hard to Lose."[223]

Oprah's eviction of "diet" is thus, if not an entirely moot point, at least a contradictory one. The cultural baggage of "diet" is only temporarily elided by its replacement with "health," emotional well-being and discipline (all equally slippery, though no less loaded, terms). In a somewhat empty gesture, Oprah's weight loss discourse substitutes the self-denial of dieting with the self-discipline of customized "plans," both of which still construct the feminized body as an object to control. "Diet" conventionally suggests control over food alone. This discourse prescribes a more "holistic" feminine disciplinarity of restricted food "choices," time regulation, detailed exercise regimes and daily personal commitments. That generic diets are replaced with "customization" reflects a further individualization of disciplinary force: not only are the practices of disciplinary normalization incorporated into the psyche so that the individual woman polices her own conformity, they are "customized" to her own particular disciplinary failures and flaws. Indeed, "the domain of panopticism is . . . that whole lower region, that region of irregular bodies, with their details, their multiple movements, their heterogeneous forces, their spatial relations."[224]

This particular construction of weight loss may suggest feminist potential, though, as others have suggested of Winfrey's broader therapeutic discourse of self-help.[225] By focusing on health and individualistic well-being, the standard cultural rhetoric of feminine thinness may be temporarily muted, potentially enabling a separation of weight loss from the constraints of normative femininity. Extending Susan Bordo's contention that a politicized text may be read in the embodied expressions of constrained feminine identity,[226] a message of transformative empowerment may be read on the re/formed bodies of Oprah's campaign for women's wellness. Her weight loss success guests voice what Kim Chernin articulated of the thin aesthetic in the early 1980s: thinness provides certain social and cultural rewards.[227] That "health" may be one of these rewards complicates any critique of this renewed feminine aesthetic. Far from superficial, thousands of women, empowered by the knowledge that Oprah shares and emulates, are seemingly taking control of their health, finding strength in their bodies and transforming their traumas into renewed identities. But, another message is to be read: one of bodily control that signifies again the long standing notion of the female body as out of control. In this bodily message, control constitutes precisely that which will empower women—physically, spiritually, emotionally. This empowerment could be dismissed as false consciousness, but the words of Oprah's guests remain and are reiterated in the next *Oprah Show* on weight loss, the next edition of *O*, the next instalment of Oprah's weight loss "boot camps." Weight loss still signifies self-transformation, and this transformation still empowers individual women.

But, as Chernin points out, the rewards for thinness are illusory and fleeting.[228] The same terms of medicalization, enculturation and "self-improvement" that interpellate the "thin woman" as "re/formed" hail the "fat woman" into the "before" frame. As such, "fat," "obese," "overweight," "morbid" must be continually resignified through the disciplinary regimes of Oprah's weight loss discourse. The absencing of "fat" is a perpetual process that discursively symbolizes the female body as *always* too much, but *never* thin enough, good enough—and now—healthy enough. In an interesting (and somewhat paradoxical) parallel to Oprah's campaign for each woman to "live her best life," Chernin also suggests that the "tyranny of slenderness" requires women to deny their "hungers," whether physical, emotional, material or spiritual. This denial, in turn, ensures that they take up less space with their bodies, make fewer demands, have fewer expectations.[229] In Oprah's campaign, the embodied denial through which weight loss signifies self-transformation is instead read as "becoming more of who you are"; the fat "before" is overwritten with the "thin" after, but this denial produces a new set of fears. Within this embodied reiteration, disciplinary failure is ever imminent. This discursive and embodied failure may be potentially resuscitated by Winfrey's brand of spiritualism (if it does, in fact, supersede the physical reality of the re/formed body), but it is also premised on the re/formation of psyche and soma via the metamorphosis induced by weight loss, returning women again to thinness and bodily control as linchpins of appropriate feminine embodiment.

The re/formed body of Oprah's televisual clinical space thus exposes "health" as inextricably bound together with the sociocultural production of constrained feminine identity. The question becomes how to negotiate "health" within the punitive parameters of normative feminine discipline, a complex undertaking that can only emerge from individual women's struggles within the multiple discourses through which they reiteratively produce their embodied identities. However this negotiation occurs, the re/formed feminine aesthetic of Oprah's weight loss discourse illustrates one of Foucault's statements on medicine: "the body is a biopolitical reality; medicine is a biopolitical strategy."[230] This re/formed feminine aesthetic is at once produced by "health," constrained by "health" and transformed by the terms of this televisual clinical discourse. Moreover, Foucault asserts that, to reveal the mechanisms of power at work in a particular sociohistorical moment, "one needs to study what kind of body the current society needs."[231] The re/formed female bodies that emerge from Winfrey's multi-media clinical space reveal that the "kind of [female] body the current society needs" is not only one multiply constructed to conform, but "healthy" to boot. As Oprah might say, you just have to make the connection.

Notes

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[1] *The Oprah Winfrey Show*, "Incredible Weight-Loss Follow-Ups," April 24, 2003, 3-4.

[2] I list references to *Oprah Show* transcripts with full citation details in order to distinguish the numerous "weight loss" programs analyzed.

[3] Oprah.com, "About Oprah: The Press Room – Oprah Winfrey's Biography," http://www2.oprah.com/about/press/about_press_bio.jhtml (accessed September 30, 2005).

[4] Oprah.com, "About Oprah: Oprah.com Facts," http://www2.oprah.com/about/press/ about_press_comfaq.jhtml (accessed September 30, 2005).

[5] Oprah.com, "About Oprah: Oprah Winfrey's Biography – Magazine Founder and Editorial Director," http://www2.oprah.com/about/press/about_press_bio.jhtml (accessed September 30, 2005).

[6] Circulation statistics from the Magazine Publishers of America suggest that *O: The Oprah Magazine* is currently the fifth best selling magazine based on single copy circulation (ranking behind *Cosmopolitan*, *Woman's World*, *People* and *First For Women*). *O: The Oprah Magazine* currently ranks forty-first in subscription circulation, and ranks twenty-first in overall circulation (including both single copy circulation and subscription circulation). See, respectively, Magazine Publishers of America, "Avg. Single Copy Circulation for Top 100 ABC Magazines, 2005, First Six Months," http://www.magazine.org/ Circulation/

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circulation_trends_and_magazine_handbook (accessed September 30, 2005); Magazine Publishers of America, “Avg. Subscription Circulation for Top 100 ABC Magazines, 2005, First Six Months,” http://www.magazine.org/Circulation/ circulation_trends_and_magazine_handbook (accessed September 30, 2005); and, Magazine Publishers of America, “Avg. Circulation for Top 100 ABC Magazines, 2005, First Six Months,” http://www.magazine.org/Circulation/ circulation_trends_and_magazine_handbook (accessed September 30, 2005).

[7] Oprah.com, “About Oprah: Oprah Winfrey’s Biography – Honorary Achievements,” http://www2.oprah.com/about/press/about_press_bio.jhtml (accessed September 30, 2005); and, United Nations Association of the United States of America and the Business Council for the United Nations, “Media Alert,” http://www.unausa.org/site/ pp.asp?c=fvKRI8MPJpF&b=388193 (accessed October 25, 2005).

[8] Ignatius, “The People Who Influence Our Lives”; Steinem, “Oprah Winfrey”; and, Time.com, “Who are the Most Influential 100 People?,” http://www.time.com/ question/2005time100.html (accessed September 30, 2005).

[9] Forbes.com, “Special Report: The Celebrity 100,” http://www.forbes.com/ celebrities (accessed October 7, 2005); and, Forbes.com, “Special Report: The Celebrity 100 – Oprah Winfrey,” http://www.forbes.com/lists/2005/53/O0ZT.html (accessed October 7, 2005).

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[10] Oprah Winfrey ranked 235th on *Forbes'* list of the 400 Richest Americans. See Forbes.com, "Special Report: The 400 Richest Americans," http://www.forbes.com/400richest/ (accessed September 29, 2005).

[11] Oprah Winfrey ranked 507th out of 691 billionaires who made the *Forbes* list in 2005. See Forbes.com, "Special Report: The World's Billionaires," http://www.forbes.com/2005/03/09/bill05land.html (accessed September 29, 2005).

[12] Oprah.com, "About Oprah: Oprah Winfrey's Biography," http://www2.oprah.com/ about/press/about_press_bio.jhtml (accessed September 30, 2005).

[13] Forbes.com, "Special Report: The World's Billionaires – Oprah Winfrey," http://www.forbes.com/2005/03/09/billl05land.html (accessed September 29, 2005).

[14] Though often a fuzzily defined term in Winfrey's televisual discourse, women's "empowerment" is a central feature of how *The Oprah Winfrey Show* defines itself. Corrine Squire notes, for instance, that

> the show's feminism is most explicit . . . in its often-declared commitment to empowering women. This term has multiple meanings, indicating variously an interest in women's political, economic, and educational advancement; in women getting help for personal and relationship problems; and most generally, in women perceiving a range of individual and social choices as open to them and deciding among them. Each meaning implies a different version of feminism. The first suggests a

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> public, the second a personal focus for feminism and the last founds feminist politics in psychological well-being. Nevertheless the show's representations of empowerment all assume a commonality between women that allows the representations to make the category “women” their unproblematic centre. Feminism must use this category to ground its analyses and claims, but the category always has a social and historical context that gives it a specific meaning (Riley, 1988; Spelman, 1990). *Oprah*, however, represents women as sharing emotional and social qualities—communication skills, for instance—regardless of the differences between women. The show's aim is to empower this shared womanhood.

See Squire, “Empowering Women?,” 102.

[15] Hearst Corporation, “O Media Kit: In Her Words – ‘Become More of Who You Are’,” http://www.omediakit.com/r5/showkiosk.asp?listing_id=385219&category_code=edit (accessed September 28, 2005).

[16] Ibid.

[17] See, for example, Haarman, “Performing Talk,” esp. 43-54; Masciarotte, “C'mon Girl,” 82-83.

[18] Squire, “Empowering Women?,” 99.

[19] *O: The Oprah Magazine*, “Lose Weight with Oprah,” February 2005, 114.

[20] Ibid., 112, 114.

[21] Ibid.

[22] *The Oprah Winfrey Show*, “Oprah's Weight Loss Plan,” February 14, 2005.

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[23] *O: The Oprah Magazine*, "Lose Weight with Oprah," February 2005, 109, 112.

[24] *The Oprah Winfrey Show*, "Lose Weight this Summer with Oprah: Boot Camp Follow-ups," May 12, 2005, 3.

[25] *O: The Oprah Magazine*, "Lose Weight with Oprah," February 2005, 109-110 (emphasis in original).

[26] See Brody, "Here's to Your Health!"; *O: The Oprah Magazine*, "Oprah's New Shape: How She Got It," January 2003; and, *The Oprah Winfrey Show*, "Check Your Health 2003," January 2, 2003.

[27] See *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002; *The Oprah Winfrey Show*, "Emotional Eating Follow-up," March 15, 2002; and, *The Oprah Winfrey Show*, "Emotional Eating Follow-up," July 18, 2002.

[28] See *The Oprah Winfrey Show*, "Dr. Phil's Weight-Loss Advice (Part 1)," January 30, 2001; *The Oprah Winfrey Show*, "Dr. Phil's Weight-Loss Advice (Part 2)," February 6, 2001; *The Oprah Winfrey Show*, "Dr. Phil's Weight-Loss Advice (Part 3)," February 13, 2001; and, *The Oprah Winfrey Show*, "Dr. Phil's Weight-Loss Follow-Ups," June 12, 2001.

[29] See, in chronological order, *The Oprah Winfrey Show*, "Lifestyle Makeovers," May 29, 2000; *The Oprah Winfrey Show*, "Lifestyle Makeovers: The Energy of Money," September 18, 2000; *The Oprah Winfrey Show*, "Lifestyle Makeovers: Living With Integrity," September 25, 2000; *The Oprah Winfrey Show*, "Lifestyle Makeovers: Toxic Relationships," October 9, 2000; *The Oprah Winfrey Show*, "Lifestyle Makeovers: Fueling Relationships," October 16, 2000; *The Oprah Winfrey Show*, "Lifestyle Makeovers: What Do You Need to Surrender?,"

October 30, 2000; *The Oprah Winfrey Show*, "Intentions for 2001," January 22, 2001; *The Oprah Winfrey Show*, "Lifestyle Makeovers: How to Set Personal Boundaries," February 5, 2001; *The Oprah Winfrey Show*, "Lifestyle Makeovers: Is Your Lifestyle Ruining Your Health?," February 19, 2001; *The Oprah Winfrey Show*, "Lifestyle Makeovers: How to Find Your Passion," March 5, 2001; *The Oprah Winfrey Show*, "Lifestyle Makeovers: Pursuing Your Passion," April 9, 2001; *The Oprah Winfrey Show*, "Lifestyle Makeovers: Are You Listening to Your Life?," April 23, 2001; *The Oprah Winfrey Show*, "Lifestyle Makeovers: How Well Do You Cope?," May 7, 2001; and, *The Oprah Winfrey Show*, "Lifestyle Makeovers Celebration," May 14, 2001.

[30] *The Oprah Winfrey Show*, "Gary Zukav on Healing Your Addiction," September 27, 1999; *The Oprah Winfrey Show*, "People Addicted to Food," October 4, 1999; *The Oprah Winfrey Show*, "Carbohydrate Addicts Weight Loss Follow-up," October 11, 1999; and, *The Oprah Winfrey Show*, "Carb Addicts' Weight Loss Follow-up," November 18, 1999.

[31] In 1988, Winfrey now famously paraded on stage in size 10 Calvin Klein jeans, and pulling a wagon of lard, to reveal the weight she had lost following the Optifast diet program. For discussion of this event, See *O: The Oprah Magazine*, "Oprah's New Shape: How She Got It," January 2003, 54; and, Oprah.com, "Unforgettable! Oprah's 67-Pound Weight Loss," http://www2.oprah.com/presents/2005/20anniv/oprah/oprah_moments_284_101.jhtml (accessed December 1, 2005).

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[32] Illouz, *Oprah Winfrey and the Glamour of Misery*, 39.

[33] Ibid., 40.

[34] Ibid., 41.

[35] Greene and Winfrey, *Make the Connection*.

[36] See, for example, *The Oprah Winfrey Show*, "Check Your Health 2003," January 2, 2003; and, *The Oprah Winfrey Show*, "Oprah's Weight Loss Plan," February 14, 2005.

[37] Illouz, *Oprah Winfrey and the Glamour of Misery*, 45.

[38] Shattuc, *Talking Cure*, 57.

[39] Ibid., 58.

[40] See, for example, Shattuc, *The Talking Cure*, 56-59. See also Winfrey's own "authorized" biographical information located on her website and the various pop cultural (and quite sensational) biographies of Winfrey of which I list only a few examples: Mair, *Oprah Winfrey*; Oprah.com, "About Oprah: Oprah Winfrey's Biography – Magazine Founder and Editorial Director," http://www2.oprah.com/about/press/about_press_bio.jhtml (accessed September 30, 2005); Presnall, *Oprah Winfrey*; and, Waldron, *Oprah!*.

[41] Shattuc, *Talking Cure*, 56-57.

[42] Ibid., 57.

[43] Wilson, *Oprah, Celebrity and Formations of the Self*, 156.

[44] For discussion of the potential feminism of Winfrey's televisual discourse, see Illouz, *Oprah Winfrey and the Glamour of Misery*; Shattuc, "The Oprahification

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of America"; Squire, "Empowering Women?"; and, Wilson, *Oprah, Celebrity and Formations of the Self.*

[45] Illouz, *Oprah Winfrey and the Glamour of Misery*, 31.

[46] These terms are necessarily complex and difficult to define: race, class, sex, gender, sexuality and nation have each been rightly interrogated, unsettled and deconstructed by post-structural theorists. However, their everyday usage in the *Oprah* televisual discourse, and in other similar pop cultural milieux, remains largely unproblematized—at least, within these cultural setting. While Oprah does address issues of race, class, gender and sexuality (which I discuss later in the chapter), their "common meanings" are generally reiterated in her televisual discourse.

[47] Illouz, *Oprah Winfrey and the Glamour of Misery*, 156-57.

[48] Shattuc, "The Oprahification of America," 174.

[49] I extend the binary divisions that Illouz suggests are exploded by Oprah Winfrey's persona; Illouz's discussion of Winfrey's queering of everyday life also applies. See, respectively, Illouz, *Oprah Winfrey and the Glamour of Celebrity*, 53-54, and 66-75.

[50] Squire, "Empowering Women?," 104-5.

[51] Wilson, *Oprah, Celebrity and Formations of Self*, 72-74.

[52] Illouz, *Oprah Winfrey and the Glamour of Celebrity*, 180.

[53] These binaries align with the discursive construction of the "public sphere" as masculine. For extended discussion of the Oprah's televisual discourse and its relation to the democratization (or, in some readings, destruction) of the public

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sphere, see Dean, "Coming Out as an Alien"; Illouz, *Oprah Winfrey and the Glamour of Misery*; Masciarotte, "C'mon Girl"; Shattuc, "The Oprahification of America"; Squire, "Empowering Women?," and, Tolson, "Talking About Talk."

[54] Wilson, *Oprah, Celebrity and Formations of Self*, 156.

[55] For extensive discussion on the academic and mainstream debates over talk show television, and in particular whether this cultural/media genre provides a (potentially renewed) public forum for individuals, deconstructs the public/private divide which disempowers the voices of certain individuals, or debases the concepts underlying democratizing public speech entirely, see for example, Dean, "Coming Out as an Alien"; Livingstone and Lunt, *Talk On Television*; Lowney, *Baring Our Souls*; Manga, *Talking Trash*; Scott, *Can We Talk?*; Shattuc, *The Talking Cure*; and, Tolson, "Talking About Talk."

[56] See, for example, Haarman, "Performing Talk"; Masciarotte, "C'mon, Girl"; and, Shattuc, *The Talking Cure*, 95.

[57] Squire, "Empowering Women?."

[58] Dean, "Coming Out as an Alien," 96.

[59] The brutal history of racism in the United States is an exception to this cursory treatment of socio-historical hegemonies, however, as it is a consistent narrative thread throughout Winfrey's televisual discourse; racism is just as likely to be raised in an *Oprah Show* program on weight loss, as it is on a program about race relations, poverty, or black masculinity.

[60] Squire, "Empowering Women?," 102 (emphasis in original).

[61] Wilson, *Oprah, Celebrity and Formations of Self*, 14.

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[62] *The Oprah Winfrey Show*, "Weight Loss Success Stories," January 19, 2004, 4.

[63] Foucault, *Birth of the Clinic*, 110-11.

[64] Denzin, "The Birth of the Cinematic Surveillance Society," 120. See also my discussion and use of Denzin in Chapter 1, "The Postmodern Cultural Clinic."

[65] Foucault, *Discipline and Punish*, esp. 135-41, 195-228. For extensive discussionof the disciplinary gaze, see Chapter 1, "The Postmodern Cultural Clinic."

[66] Mulvey, "Visual Pleasure and Narrative Cinema." Regarding the *Oprah* televisual discourse, in particular, Corrine Squire notes the multiple ways in which conventional representations of beauty are constructed on *The Oprah Show* (e.g., make-over episodes, images of Oprah at her thinnest), thereby establishing "women as objects of beauty." Interrogating these representations, Squire suggests that such examples

> could operate as a powerful screen player in the cultural and psychic masquerade of femininity . . . . beginning with Laura Mulvey, feminist film theorists have argued that such representations of femininity put the spectator in a complementary masculine position of pleasure and desire (Mulvey, 1975, 1981). *Oprah*'s predominantly female studio and viewing audience is thus set up to look at the feminine object, Winfrey, from a patriarchal position: as men. The audience may either adopt this masculine spectatorship or abdicate spectatorship for an identification with the femininity on screen (see also de Lauretis, 1991; Doane, 1987). Such work suggests that *Oprah* offers women a variety of psychic investments, so its

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> feminism will not be a simple matter of women watching women but will filter through the multiple subjectivities of spectatorship.

See Squire, "Empowering Women?," 102-3 (emphases in original).

[67] See Chapter 1, "The Postmodern Cultural Clinic," for extensive discussion of the multiplicitous gaze of the postmodern cultural clinic.

[68] For example, the Oprah.com entries related to the *Oprah Show* program "Insiders' Guide to Make You Younger and Healthier" include the standard legal warning: "Any advice given or treatments suggested is of a general nature and it is recommended that you consult with an outside professional (medical or otherwise) for advice and treatments specific to you." See Oprah.com, "Mind and Body: The You Docs," http://www.oprah.com/health/yourbody/youdocs/youdocs_mains.jhtml (accessed November 14, 2005); and, *The Oprah Winfrey Show*, "Insiders' Guide to Make You Younger and Healthier," May 3, 2005.

[69] *The Oprah Winfrey Show*, "The Number One Killer of Women Revealed," October 19, 2005.

[70] Ibid. See also Oprah.com, "Love Your Heart: A New Technology," http://www.oprah.com/health/yourbody/slide/numberone/slide_yourbody_number one _102.jhtml (accessed November 11, 2005).

[71] See *The Oprah Winfrey Show*, "New Medical Tests," October 2, 2000.

[72] See, for example, *O: The Oprah Magazine*, "Oprah's New Shape: How She Got It," January 2003.

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[73] See, for example, *The Oprah Winfrey Show*, "Recipes for Your Heart," April 8, 2002; *The Oprah Winfrey Show*, "What to Feed Your Heart," March 13, 2002; and, Ornish and Oz, "Strong at Heart."

[74] *O: The Oprah Magazine*, "Oprah's New Shape: How She Got It," January 2003, 53. See also *O: The Oprah Magazine*, "Be Aware, Be Very Aware: Oprah's Own Story," August 2002; and, *O: The Oprah Magazine*, "The Heart of a Woman," May 2002.

[75] *The Oprah Winfrey Show*, "The Big M – Menopause," March 7, 2001; and, *The Oprah Winfrey Show*, "Dr. Christiane Northrup," January 27, 1999. See also Northrup, *The Wisdom of Menopause*; and, Northrup, *Women's Bodies, Women's Wisdom*.

[76] *The Oprah Winfrey Show*, "Real Age Follow-Ups," September 20, 1999; and, *The Oprah Winfrey Show*, "What's Your Real Age?," February 25, 1999. See also Roizen, *RealAge*; Rosenfeld, *Live Now, Age Later*; and, Walford and Walford, *The Anti-Aging Plan*.

[77] *The Oprah Winfrey Show*, "Mammograms, Self-Exams, Hormone Therapy—Why are We So Confused?," October 10, 2002. See also Love, *Dr. Susan Love's Breast Book*; and, Reichman, *Relax, This Won't Hurt*.

[78] *The Oprah Winfrey Show*, "Health Mistakes Smart Women Make," June 7, 2001. See also Indichova, *Inconceivable*; and, Oprah.com, "Know Your Body Expert Alice Domar, PhD," http://www.oprah.com/presents/2004/kyb/experts/kyb_expert_domar.jhtml (accessed November 14, 2005).

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[79] *The Oprah Winfrey Show*, "Insiders' Guide to Make You Younger and Healthier" May 3, 2005. See also Roizen and Oz, *You: The Owner's Manual*.

[80] *The Oprah Winfrey Show*, "Health Mistakes Smart Women Make," June 7, 2001.

[81] *The Oprah Winfrey Show*, "What the Experts Wish You Knew," June 22, 2000.

[82] *The Oprah Winfrey Show*, "Outrageous Medical Mistakes," October 3, 2003.

[83] Blumenfeld, "Let's Get Physical: Checkup Checklist."

[84] Stone, "Who's the Boss? How to Ensure You Get A-Plus Medical Care."

[85] Gorney, "Ask for What You Want 100 Percent of the Time."

[86] "Know Your Body" is the slogan associated with the Lluminari women's health initiative on Oprah.com.See Oprah.com, "Know Your Body," http://www.oprah.com/ presents/2004/kyb/kyb_main_landing.jhtml (accessed November 14, 2005).

[87] See, for example, Squire, "Empowering Women?," 107-9. Squire argues that Winfrey skilfully shifts between the valorization of individual experience, producing at times an anti-professionalism, and the authority of found in professionalized discourses such as psychology.

[88] Foucault, *Birth of the Clinic*, 34-35 (emphasis in original).

[89] In a large body of literature, see for example, Laurence and Weinhouse, *Outrageous Practices*; Lorber and Moore, *Gender and the Social Construction of Illness*; Lupton, *Medicine as Culture*; Oakley, *The Captured Womb*; Riessman, "Women and Medicalization"; Scambler, "Gender, Health and Feminist Debate";

Shildrick, *Leaky Bodies*; and, Weitz, *The Politics of Women's Bodies*. For further discussion, see also Chapter 1, "The Postmodern Cultural Clinic."

[90] Foucault, *Power*, 137.

[91] Ibid., 120.

[92] See, for example and respectively, *The Oprah Winfrey Show*, "The Big M – Menopause," March 7, 2001; *The Oprah Winfrey Show*, "What It's Like to be Fat," January 17, 2002; and, *The Oprah Winfrey Show*, "Check Your Health 2003," January 2, 2003.

[93] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 9. See also: *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002.

[94] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," November 9, 2000, 11.

[95] *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002, 6.

[96] *The Oprah Winfrey Show*, "Incredible Weight-Loss Follow-Ups," April 24, 2003, 11.

[97] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 21-22.

[98] *The Oprah Winfrey Show*, "Check Your Health 2003," January 2, 2003, 2.

[99] *The Oprah Winfrey Show*, "Weight Loss Success Stories," January 19, 2004, 1.

[100] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 1.

[101] *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002, 1.

[102] *The Oprah Winfrey Show*, "Weight Loss Success Stories," January 19, 2004, 10.

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[103] *The Oprah Winfrey Show*, "Lose Weight this Summer with Oprah: Boot Camp Follow-Ups," May 12, 2005, 1.

[104] Brody, "Here's to Your Health!," 132.

[105] Ibid. See also Oprah.com, "Here's to Your Health! Program – The Mission," http://www.oprah.com/presents/lluminari/whatis/llum_whatis_mission.jhtml (accessed November 15, 2005).

[106] See, for example, *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," November 9, 2000, 18. In this "weight loss" program, Oprah declares that what she loves about weight loss stories is "being the size that's right for you." I discuss this contradiction further in the final section of this chapter.

[107] *The Oprah Winfrey Show*, "Weight Loss Success Stories," January 19, 2004, 1.

[108] Ibid., 9.

[109] Ibid., 9.

[110] Ibid., 12.

[111] Ibid., 16.

[112] Ibid., 12.

[113] See, for example, *O: The Oprah Magazine*, "Oprah's New Shape: How She Got It," January 2003, 56; and, *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 1.

[114] *O: The Oprah Magazine*, "Lose Weight With Oprah," February 2005, 112, 114.

[115] Greene, *Bob Greene's Total Body Makeover*.

[116] Winfrey and Greene, *Make the Connection*.

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[117] See Chapter 1, "The Postmodern Cultural Clinic," for more extensive discussion of this cultural paradox.

[118] See, for example, Hearst Corporation – O Media Kit, "In Her Words: 'Become More of Who You Are'," http://www.omediakit.com/r5/showkiosk.asp?listing_id=385219 &category_code=edit (accessed September 28, 2005). "Become more of who you are" is one of Winfrey's many catch phrases, repeated across the venues of her multi-media empire as an expression of her "live your best life" campaign.

[119] See *The Oprah Winfrey Show*, "What It's Like to be Fat," January 17, 2002.

[120] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," November 9, 2000, 16.

[121] *The Oprah Winfrey Show*, "Weight Loss Success Stories," January 19, 2004, 6.

[122] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 1.

[123] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 7.

[124] *The Oprah Winfrey Show*, "Incredible Body Makeovers and Follow-Up with Wynonna Judd," November 8, 2004, 3.

[125] See, for example, *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 18; and, *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," February 10, 2003, 6.

[126] For instance, Winfrey gave one male "weight loss success" guest a Porsche sports car; for another, who was finally dating again after twenty years, she orchestrated a romantic evening. See *The Oprah Winfrey Show*, "Incredible Weight-Loss Follow-Ups," April 24, 2003, 8-9, 16-17.

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[127] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 9.

[128] *The Oprah Winfrey Show*, "Incredible Weight-Loss Follow-Ups," April 24, 2003, 7.

[129] *The Oprah Winfrey Show*, "Oprah's Weight Loss Plan," February 14, 2005, 16.

[130] *The Oprah Winfrey Show*, "Incredible Weight-Loss Follow-Ups," April 24, 2003, 11.

[131] *The Size of It*, directed by Dylan Robertston, as cited on *The Oprah Winfrey Show*, "What It's Like to be Fat," January 17, 2002, 2-3.

[132] *The Oprah Winfrey Show*, "Weight Loss Success Stories," January 19, 2004, 10.

[133] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," November 9, 2000, 16.

[134] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," February 10, 2003, 12.

[135] *The Oprah Winfrey Show*, "Incredible Body Makeovers and Follow-Up with Wynonna Judd," November 8, 2004, 2.

[136] While much as been written on the "grotesque," for discussion of fatness, female identity and cultural spectacle see Braziel and LeBesco, *Bodies Out of Bounds*; Feuer, "Averting the Male Gaze"; and, Lowney, *Baring Our Souls*. Ironically, in mainstream culture, "fat" women are also often "seen" as invisible. On this point, see for example, Goodman, *The Invisible Woman*.

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[137] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," February 10, 2003, 15.

[138] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 18.

[139] Ibid., 18.

[140] *The Oprah Winfrey Show*, "Incredible Body Makeovers and Follow-Up with Wynonna Judd," November 8, 2004, 2.

[141] Ibid., 2.

[142] Ibid., 9-10.

[143] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," February 10, 2003, 4.

[144] Ibid., 6.

[145] Ibid., 16.

[146] *The Oprah Winfrey Show*, "Oprah's Weight Loss Plan," February 14, 2005, 16.

[147] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 7.

[148] *The Oprah Winfrey Show*, "Incredible Body Makeovers and Follow-Up with Wynonna Judd," November 8, 2004, 1.

[149] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 9.

[150] *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002, 9.

[151] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," February 10, 2003, 10.

[152] Winfrey and Greene, *Make the Connection*, 46.

[153] Ibid., 47.

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[154] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 9.

[155] *The Oprah Winfrey Show*, "Incredible Weight-Loss Follow-Ups," April 24, 2003, 14.

[156] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," November 9, 2000, 9.

[157] Ibid., 12.

[158] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," July 18, 2002, 7.

[159] *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 15.

[160] Orbach, *Fat is a Feminist Issue*.

[161] Orbach, *Fat is a Feminist Issue II*. Some examples of Orbach's self-help exercises include visualizing one's ideal kitchen (131-34), "mirror work" to become more comfortable with one's physical appearance (149-51), and recalling "the family meal" of one's childhood (157-59).

[162] See Orbach, *Fat is a Feminist Issue*, preface and chap. 1.

[163] *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002, 11-12.

[164] Orbach, *Fat is a Feminist Issue*, 78.

[165] Ibid., 42-43.

[166] Orbach, *Fat is a Feminist Issue II*, 14.

[167] See, for example, *The Oprah Winfrey Show*, "Emotional Eating," January 3, 2002, 15; and, Winfrey and Greene, *Make the Connection*, 58-60, 226-30.

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[168] See, for example, *The Oprah Winfrey Show*, "Emotional Eating Follow-Up," March 15, 2002, 12-13; Orbach, *Fat is a Feminist Issue*, 103-26; and, Orbach, *Fat is a Feminist Issue II*, 37-50;

[169] Orbach, *Fat is a Feminist Issue*, 126.

[170] Ibid., 4.

[171] Ibid., 6 (emphasis in original).

[172] *The Oprah Winfrey Show*, "Have You Let Yourself Go?," October 31, 2005, 2.

[173] Ibid., 4.

[174] Ibid.

[175] Ibid., 7.

[176] *The Oprah Winfrey Show*, "Check Your Health 2003," January 2, 2003, 17.

[177] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," February 10, 2003, 10.

[178] Ibid., 17.

[179] *The Oprah Winfrey Show*, "Incredible Weight Loss Stories," November 9, 2000, 17.

[180] *The Oprah Winfrey Show*, "Incredible Weight Loss Success Stories," February 10, 2003, 14.

[181] "Metamorphosis" is defined as "the action or process of changing in form, shape, or substance" and, alternatively, as "a complete change in the appearance, circumstances, condition, or character of a person." For these *Oprah* guests, the change in "form, shape, or substance," "appearance, circumstances, condition or character" produced through weight loss enables them to "become someone new."

See *Oxford English Dictionary Online*, s.v. “Metamorphosis,” http://www.oed.com/.

[182] For extensive discussion of disciplinary normalizations, see Chapter 1, “The Postmodern Cultural Clinic.”

[183] *The Oprah Winfrey Show*, “Incredible Weight Loss Stories,” November 9, 2000, 18.

[184] *The Oprah Winfrey Show*, “Emotional Eating Follow-Up,” March 15, 2002, 7.

[185] *The Oprah Winfrey Show*, “Incredible Body Makeovers and Follow-Up with Wynonna Judd,” November 8, 2004, 1.

[186] *The Oprah Winfrey Show*, “Oprah’s Weight Loss Plan,” February 14, 2005, 14.

[187] Ibid., 5, 7.

[188] *The Oprah Winfrey Show*, “Emotional Eating Follow-Up,” March 15, 2002, 1.

[189] *The Oprah Winfrey Show*, “Lose Weight This Summer with Oprah: Boot Camp Follow-Ups,” May 12, 2005, 3.

[190] Ibid., 19.

[191] *The Oprah Winfrey Show*, “Check Your Health 2003,” January 2, 2003, 16.

[192] *The Oprah Winfrey Show*, “Incredible Weight-Loss Follow-Ups,” April 24, 2003, 10.

[193] Ibid., 12.

[194] Ibid., 13.

[195] *The Oprah Winfrey Show*, “Weight Loss Success Stories,” January 19, 2004, 4.

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[196] *The Oprah Winfrey Show*, “Lose Weight This Summer With Oprah: Boot Camp Follow-Ups,” May 12, 2005, 14.

[197] *The Oprah Winfrey Show*, “Oprah’s Weight Loss Plan,” February 14, 2005, 7.

[198] *O: The Oprah Magazine*, “Oprah’s New Shape: How She Got It,” January 2003, 56.

[199] Ibid., 55.

[200] *The Oprah Winfrey Show*, “Emotional Eating Follow-Up,” July 18, 2002, 1.

[201] Ibid., 9.

[202] *The Oprah Winfrey Show*, “Incredible Weight-Loss Follow-Ups,” April 24, 2003, 4-5.

[203] Squire, “Empowering Women?,” 102 (emphasis in original).

[204] Oprah.com, “*The Oprah Winfrey Show*: Check Your Health 2003,” http://www2.oprah.com/tows/pastshows/200301/tows_past_20030102.jhtml (accessed October 10, 2005).

[205] See, for instance, *The Oprah Winfrey Show*, “Lose Weight This Summer With Oprah: Boot Camp Follow-Ups,” May 12, 2005.

[206] *The Oprah Winfrey Show*, “Weight Loss Success Stories,” January, 19, 2004, 5.

[207] *The Oprah Winfrey Show*, “Lose Weight This Summer with Oprah: Boot Camp Follow-Ups,” May 12, 2005, 1.

[208] *The Oprah Winfrey Show*, “Check Your Health 2003,” January 2, 2003, 5.

[209] “The Non-Diet Diet,” *O: The Oprah Magazine*, June 2005, cover; see also Body Wise, *O: The Oprah Magazine*, June 2005, 129-130.

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[210] "The 'Yes, I Can!' Diet," *O: The Oprah Magazine*, September 2005, cover; and, Fain, "The *Yes, I Can!* Diet."

[211] "Why Weight Watchers Still Works," *O: The Oprah Magazine*, October 2005, cover; and, Birnbaum, "The Weight Watchers Secret of Success."

[212] "Diet Doctor's Diet Secrets," *O: The Oprah Magazine*, May 2005, cover; and, Wildman, "Even Weight Experts Get the Munchies."

[213] "Three Crash Diets—Doctor Approved!," *O: The Oprah Magazine*, August 2003, cover; and, Stacey, "The Doctors' Own Kick-Start Diets."

[214] "Twenty Diet Tactics," *O: The Oprah Magazine*, December 2004, cover; and, Mithers, "Twenty Ways to Win at Losing."

[215] "The All-Day-Energy Diet," *O: The Oprah Magazine*, July 2002, cover; and, Davis, "The Good-Mood Diet."

[216] See, for example, Shell, "One Can Make You Small"; and, Stacey, "Another Bitter (Diet) Pill."

[217] "Diet Pills: The Next Generation," *O: The Oprah Magazine*, July 2005, cover; and, Fischer, "Diet Pills: The Next Generation."

[218] In a large collection of articles and issues from *O: The Oprah* Magazine, see for example, *O: The Oprah Magazine*, "Be Aware, Be Very Aware: Oprah's Own Story," May 2002; "How to Eat," *O: The Oprah Magazine*, August 2004; Brody, "Here's To Your Health!"; *O: The Oprah Magazine*, "Lose Weight With Oprah," February 2005; and, *O: The Oprah Magazine*, "Oprah's New Shape: How She Got It," January 2003.

[219] McGraw, "The Ultimate Weight Solution."

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[220] "The Buddy System: Lose Weight Together," *O: The Oprah Magazine*, August 2001, cover; and, Kamps, "Let's Get Down (a Few Pounds) Together."

[221] "Have You Hit the Weight-Loss Wall? Seven Ways to Get Over," *O: The Oprah Magazine*, August 2003, cover; and, Katz, "When Good Diets Go Bad."

[222] "Keep It Off—Forever! Ten Rules of Permanent Weight Loss," *O: The Oprah Magazine*, August 2004, cover; and, Dunn, "Keeping It Off—Forever."

[223] "Weight – Why It's so Hard to Lose," *O: The Oprah Magazine*, August 2002, cover; and, Stacey, "Losing It."

[224] Foucault, *Discipline and Punish*, 208.

[225] See, for example, Dean, "Coming Out as an Alien"; Illouz, *Oprah Winfrey and the Glamour of Misery*; Shattuc, "The Oprahification of America"; Squire, "Empowering Women?"; and, Wilson, *Oprah, Celebrity and Formations of the Self.*

[226] Bordo, *Unbearable Weight*, 168.

[227] Chernin, *The Obsession*, 47-48.

[228] Ibid.

[229] Ibid.

[230] Foucault, *Power*, 137.

[231] Foucault, *Power/Knowledge*, 58.

Chapter 4: Pro-Anorexia: Crossing the Virtual Line

I believe in Control, the only force mighty enough to bring order to the chaos that is my world.

I believe that I am the most vile, worthless and useless person ever to have existed on this planet, and that I am totally unworthy of anyone's time and attention.

I believe that other people who tell me differently must be idiots. If they could see how I really am, then they would hate me almost as much as I do.

I believe in perfection and strive to attain it.

I believe in salvation through trying just a bit harder than I did yesterday.

I believe in bathroom scales as an indicator of my daily successes and failures.

I believe in hell, because I sometimes think that I am living in it.

I believe in a wholely [sic] *black and white world, the losing of weight, recrimination for sins, abnegation of the body and a life ever fasting.*

The Ana Creed[1, 2]

My friends and I obsess about our obsessions with the cult of thinness. In the middle of busy elementary school teas, fellow parents tell me how worried they are about their starving teenaged daughters, but some quietly admit that they are more concerned about their daughters being too fat than being too thin. Students adamantly tell me that they are just trying to be healthy ("and, what's so wrong with that?"), while others seek help for sisters, friends, mothers, aunts, girlfriends, daughters and roommates. Dissecting every morsel of food eaten and tabulating every calorie (or point), friends tell me that they're on "good" diets so I don't have to worry. And, I have watched—more than once—elementary school girls give away their lunchtime cookies and bananas because they don't want to get fat, even though they bristle with a childhood confidence I never had.

Within these contradictions, the line between diet and disorder is sometimes difficult to find. "Disordered eating" resonates with many women's experiences, or at least prompts an uneasy familiarity. Indeed, Joan Jacobs Brumberg aptly describes women's relationship with anorexia as "love-hate"[3]—love, as it may provide that elusive path to the thin body demanded of women, and hate, as it represents the tortured relationship all too many women have with their bodies. Hate, also, as an envy that bridges the gap between these two. A colleague of mine tells of the educated, middle-class, often academic women who attend her spoken word presentation of her own anorexic experiences.[4] They are wary, but they are envious: they want to know how they can catch it. Brumberg speaks of similar experiences: "I had dozens of *normal* women tell me jokingly that they 'wished they could have anorexia nervosa just for a little while'."[5]

Although these confessions do not reflect the prevalence of eating disorders, they do illustrate the currency of diet discourse within our culture. They reflect that small, but drastic, gap between the cultural norm of women's bodily dissatisfaction and the medical identification of disordered eating, an often vague gap that reveals the cultural paradox of anorexia. Anorexia represents the painful resilience of the idealized thin feminine aesthetic, but it simultaneously exposes the epitome of contemporary female shame—the female body out of control. Despite its valorization, the thin feminine aesthetic is marked by a subtle but continuous elision that ensures its cultural power is nebulous. Those women who reject or fail to meet its standards are condemned as lazy, fat, ugly, undesirable; those women who ruthlessly pursue them risk another form of derision: they have gone too far, they are vain, self-obsessed, "sick." The constraining of all women by this bodily ideal excludes each of them in turn from its achievement; but, this constraint reproduces the thin aesthetic as the elusive ideal by which to measure contemporary feminine worth.

The pro-anorexia movement, an internet-based movement that advocates disordered eating, exemplifies this productive paradox of rejection and desire, disdain and familiarity. In their extreme expressions of contemporary femininity, its participants are condemned by mainstream media, child educators and physicians as dangerous, sick women who need to be controlled. However, they also elicit a cultural fascination, as evidenced by the extent of media coverage the movement has received. We are repulsed, but we can't look away.

An already existing anorexic discourse—spanning medical, psychological, therapeutic and personal perspectives—precedes pro-anorexia as a movement. Pro-anorexia, however, synthesizes the cultural voice of anorexic women in ways that evoke a particularly intense response. Sympathy or pity are often afforded the woman struggling with anorexic practices, but no such understanding seems to extend to the pro-anorexic woman. Somehow, somewhere pro-anorexics have crossed a line. And, the movement has been repeatedly censored and rebuked for this violation. Eating disorders are already consigned to a position of "illness" in our culture (as discussed in Chapter 2); any defiant, public voice of anorexic women is then easily deemed deviant, as well.

With the broader anorexic discourse, the tenor of women's body image issues mirrors Michel Foucault's repressive hypothesis: production and prohibition in the same breath.[6] Women's multiplicitous identities are regulated through the productive constraint of their bodies, a constraint simultaneously harnessed and forsaken by women involved with anorexic practices. The biopolitics of contemporary feminine identity centre on the elusive thin feminine ideal and its entwined prescriptives for feminine practice: beauty, diet, exercise and comportment, mothering, partnering and labouring are each imprinted with expectations messily bound together with the thin aesthetic. This ideal prompts a cycle of continual failure and re-disciplining toward to its standards, perpetually reproduced through women's own daily practices. With pro-anorexia, however, this dialectic of production/prohibition becomes more explicit. Its literal prohibition prompts its profusion further into the body of virtual space; and, its continual censuring produces a rebellious reiteration of its voices.

I am cognizant of the concerns evoked by pro-anorexia—that its unpoliced discourse of disordered eating may lead people (especially children) to its practices—but I am also aware that the vehement condemnation of pro-anorexia closely parallels the broader cultural constraints placed on women. From a critical feminist perspective, pro-anorexia aligns with other extreme expressions of the disciplining of women's bodies to the needs of society. The myriad variations of "disordered eating," cosmetic surgery obsessions, Victorian "hysteria"[7] and

Friedan's mid-century "problem that has no name"[8] are but a few examples. And, established feminist work already acknowledges eating disorders as internalized feminine disciplines gone awry, coping mechanisms, and mediators of trauma, evicting the medical authority to label these practices as "diseased." Further mediated by the complexities of their individual lives, women's experiences with such practices are as particular as women themselves.

Without dismissing these complex voices, I read their words as a shared discourse, one which contextualizes their individual struggles with embodied feminine subjectivation. When reading across the texts of the pro-anorexia movement, a distinct discursive dialogue emerges. Unlike its anorexic pre-cursor, pro-anorexia provides a unique, but elusive, milieu in which anorexic culture is materialized in the impossibility of virtual space. And, it is this public—though virtually silenced—voice of pro-anorexia that distinguishes this particular expression of women's embodied struggles from others. While a discourse of bodily perfection pervades contemporary culture, pro-anorexic discourse does not adhere to its socially conventional expressions, nor does it easily take up the legitimized rhetoric of therapy and recovery. Though reflecting both conformity to and rebellion against the standards of normative femininity, its participants are also not easily seen as the inchoate unconscious anorexics of earlier feminist theory. Were it not for the particular voice of pro-anorexia, its participants might simply be dismissed as more unfortunate women who had "gone too far." Instead, their voices expose a cultural contradiction of silence surrounding women's pursuit of the thin aesthetic: we are obsessed with bodily perfection, but acknowledging its pursuit above all else is anathema to feminine norms.

Despite feminist calls for women's voices and spaces to be acknowledged—themes closely associated with eating disorders—pro-anorexia does not readily fit within a feminist perspective. Pro-anorexic women assert autonomy over their bodies; they demand voice; and they declare a right to their identity. Yet, while themes of control, self-annihilation and the pursuit of perfection prompt such practices, these women almost rabidly pursue the cultural trappings of beauty. If, as feminists, we simply reject pro-anorexia as "dangerous," we will be equally guilty of constraining its shared message of women's embodied struggles. Pro-anorexia has emerged in a space of webpages and hyper-texts precisely through the denial of its voice elsewhere. Yet, in their constrained virtual space, these women's voices can only be read or gazed at, then heard only in the familiar voices in our own heads. Their often anonymous but distasteful words ring true because we have implicitly read them before: on billboards, in magazines, on the faces of others.

In reading the cyber-texts of the pro-anorexia movement, a familiar discourse of pain and resilience emerges. Riddled with contradictions, its participants claim identity while they efface it. They disregard medical authority while they manipulate it. On many levels, pro-anorexic women are themselves rejected for failing to adhere to dominant social norms of femininity, but they simultaneously reproduce the bounds of this disciplinary apparatus. The movement elicits a paradoxical embodiment of doubled disappearance: with no legitimate social space for either their voices or practices, pro-anorexic women enter disembodied virtual space to erase the bodies with which they struggle, materializing an anorexic discourse in the immaterial space of the internet. And, while pro-anorexia is so disdained by mainstream culture, it flourishes in this space—albeit often through subterfuge and self-erasure—as an uncomfortably familiar reflection of our contemporary standards of normative femininity. In the terms of the postmodern cultural clinic, pro-anorexia exposes the convergence of medicine and feminine aesthetics in contemporary culture, at once challenging medical control over the female body and reiterating its disciplinary prompts. Ironically, pro-anorexia blatantly spatializes the contradictions of normativity femininity which it seeks to annihilate.

I undertake a detailed examination of pro-anorexic websites to expose these discursive contradictions. Although tensions exist across pro-anorexic webpages, their perpetually hyperlinked texts and repetitive imagery produce a shared discourse layered with paradox. This complex discourse continually folds in upon itself, mirroring the disappearing bodies of its participants. Within this slippage, three themes emerge, highlighting the painful contradictions of the pro-anorexic struggle with embodied feminine identity. First, the intense public response to the pro-anorexia movement hinges on the dominant definition of "anorexia" as "illness" or "disease." The discursive dialogue of the movement challenges this meaning, triggering the censure of its advocacy for "ana" as lifestyle and identity. Pro-anorexic discourse manipulates medical logic, at once taking up a mainstream rhetoric of health but also explicitly disrupting its terms in order to evade the medical gaze. In this usurpation of medical authority, pro-anorexia produces a virtual clinic through which the medical gaze may be tricked into seeing "normal" bodies, this lack of diagnosis sustaining the "ana" identity. Second, the desire to be normal infiltrates pro-anorexic discourse as well, establishing a discursive slip by which pro-anorexia aligns with the terms of normative femininity. Pro-anorexic bodily dissatisfaction, its technologies of diet and control, and the disciplinary prompt of "wanting to be normal" each mirror the reiterative production of feminine norms. But, pro-anorexia exposes the thin aesthetic as a vacuous mechanism of social control, reading it as both sign and signifier and, thereby, rendering it unpalatable in its pro-anorexic form. Finally, while the internet is championed as a realm of free expression divorced from the "meat" of the body, its ironic material reality never entirely frees the pro-anorexic woman from her bodily constraints. The disciplinary gaze—at once the invisible gaze of society and the authoritative gaze of medicine—enables her escape, but reasserts again the perpetual failure of her female body. Thus denied resolution to her embodied struggles, what remains is only the possibility of speech paradoxically produced through a *doubled* double disappearance—of bodies under erasure in the impossibility of virtual space, of the thin ideal written and rewritten outside the always imperfect space of the body, and of anonymous individuals subsumed beneath the skin of the all-consuming "Ana."

The Pro-Anorexia Movement

Emerging in the late days of twentieth century,[9] the pro-anorexia movement is made up of a series of cross-referencing websites located in the virtual space of the internet. Connected by web-rings and hyperlinks, a variety of sites exist within the broad label of "pro-ana." Presented in multiple languages suggesting global participation, pro-anorexia (often called "pro-ana" or "pro-rexie") sites support anorexia in particular, while pro-bulimia (or "pro-mia") sites support bulimia.[10] Many sites are a combination of these two, with the practices and beliefs espoused overlapping extensively. Variations of the core sites are continually emerging, each combining with or extending different elements of the broader "pro-ana" identity. "Goth" pro-ana sites, for instance, incorporate pro-anorexia with aspects of the goth subculture,[11] while suicide/death sites[12] exist alongside pro-ana material devoted to self-injury in many forms.[13] Across these sites, ethereal faeries and butterflies symbolize the pro-ana desire to escape embodied constraints, as do site names such as "Future Perfect,"[14] "Am I Invisible Yet?,"[15] and "Nothings Gonna Stop Me From Floating."[16]

The main pro-anorexia websites, often early sites which started and still feed the movement, provide the framework and core content for other, more personalized sites. Presented in a defiant voice, the thrust of these sites is the identity of "pro-ana" and its practices. As the "pro-ana" ribbon campaign asserts (see Figure 1[17]), pro-ana sites advocate anorexia as a legitimate lifestyle and identity choice, and do not view anorexia (or other eating disordered practices) as an illness, disease, or medical disorder. They do not follow with the medical model at all, in fact, and do not feel they need to be "cured." From the outside, they seem to teach individuals how to become anorexic or bulimic, and how to sustain their eating practices.

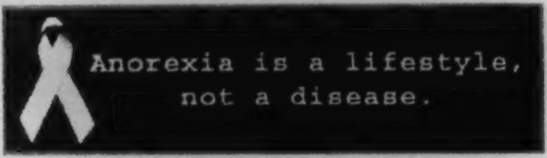

Figure 1. The "Pro-Ana" Ribbon.[18]

The analysis largely disseminated by mainstream media is that pro-anas (wrongly) promote eating disorders as a legitimate lifestyle choice. In the *New York Times Magazine*, for instance, Mim Udovitch writes that the basic premise of "pro-ana" is "that an eating disorder is not a disorder but a lifestyle choice, [which] is very much an ideology of the early twenty-first century, one that could not exist absent the anonymity and accessibility of the Internet, without which the only place large numbers of anorexics and bulimics would find themselves together would be at in-patient treatment."[19] Pro-anas add a militant tone to this definition: "this is a place where anorexia is regarded as a lifestyle and a choice, not an illness or disorder. *There are no victims here*."[20]

However, as Udovitch notes, the parameters of this status are under debate within the websites themselves.[21] While some pro-anas vehemently argue for their identity, others suggest that they are in fact ill. These cross-site debates speak both to other pro-ana participants and to individuals who challenge pro-anorexia, calling out mainstream interpretations of pro-anorexia as uninformed and close-minded. Often paralleling more mainstream debates about eating disorders, this sometimes self-reflexive pro-ana analysis shifts between the traditional medical model of disordered eating as pathological and the more sociocultural perspective of anorectic practice as a coping mechanism, reiterating the terms of these debates in different form.

For example, "Ana's Underground Grotto" expands the concept of "lifestyle choice" through the central anorexic theme of control.[22] "Pro-ana" is not only the advocacy of "anorectic *praxis*," the webmistress writes, it is also a reflection of "proactive volitional anorexia."[23] This variation on pro-anorexia "refers to actively embracing the concept of anorexia as a lifestyle choice rather than an illness. By the word 'choice' we indicate the active agency of volition, the seat of government in the human mind, the power of decision-making or of will. We are not 'ED [eating disorder] sufferers' . . . . The core praxis of anorexia involves control over oneself."[24] Here, volition and praxis separate pro-anorexia from disease, invoking the long standing cultural referents of mind over body, individual agency, and free will.

While not as audacious as the "Grotto," many pro-anas simply distinguish between "ana" as identity and "anorexia" as illness: they are not ill, they are only expressing their "true" identities.[25] Returning to the "Underground Grotto," though, the webmistress specifically coins the phrase "ED-anorexia" to refer "to anorexia as a disease or disorder, specifically an *eating* disorder (ED)," and to make a distinction between ED-anorexia and pro-anorexia. The central theme in this distinction is again volition: "The pro-ana has made a choice, and retains control of her life and choices. The ED-anorectic perceives her life to be spinning *out* of control, as her 'choices' have little to do with volition and mainly to do with bowing to internal oppressions." This line of thought continues: "Note carefully my use of the word 'perceive.' The nature of volition (choice) is such that no one can truly be said to do *anything* without exercising it."[26] The ED-anorectic, then, has simply not understood her own role in her anorexic behaviour.

Yet, certain pro-ana sites evoke medical epistemology in stark contrast to this "proactive volitional anorexia," clearly rejecting the element of choice embedded in standard pro-ana doctrine. Some participants argue that pro-anas are not advocating a "lifestyle"—it is not something so easily put on. It is not a fashion statement, as may be implied by the lifestyle label. It is an illness, a compulsion. From the mission statement of the "BlueDragonfly" website:

> I, nor this site, are trying to help anyone kill themselves . . . . Anorexia Nervosa is a mental disease that reflects an imperfection in the make up of your ability to process emotion and stimulus . . . . ANOREXIA NERVOSA IS NOT A LIFESTYLE CHOICE. You will *never* hear me say that. Anyone who believes that is wrong. Sorry. If you are indeed anorexic, you have no control over your mind, and can not make that kind of choice over what you put into your body. You crave control and think that by doing this you are indeed in control, but in fact, you have less control than you ever imagined. This sounds like an anti-statement, but hell, it's true. I even hate the term "ana" because it takes the edge [off] the seriousness of the disease – makes it conversational. Makes it the in thing.

> makes it okay. THIS SITE IS NEVER MEANT TO TEACH PEOPLE HOW TO BE ANOREXIC. I don't think it's something that you can learn anyway. And even if the tips on distracting yourself can get you to skip a meal or two one day, that does not an eating disorder make. I don't want anyone here who wants to "lose weight" . . . . Tips are to give you fresh ideas on how to stay on track so that you don't fall into a depression and kill yourself . . . . This ain't no diet. This is pure mental sickness. This site is for support.[27]

From this perspective, illness is central and control is only an illusion; the main purpose of pro-ana is support.

Most often, though, the painful reality of anorexic practices produces a more muddled middle ground, at once eroding the defiant pro-ana voice while sustaining its claim to legitimacy. "Cerulean Butterfly," for instance, admonishes individuals who seek out "pro-ana":

> If you've come here to 'learn' to be anorexic or bulimic, then you really need to leave. Eating disorders are painful, life-destroying creatures that are not worth their cost. They are not cool or glamorous. They are not a quick fix. They are not a diet. They are a living, breathing hell. But once you're in, you're in. You're in until it either kills you or destroys your life so much that you have to break free. So stay out. Stay back. Stay sane. If you do have an eating disorder, you know what a hell it is. You know how sometimes this hell is the only thing that keeps you going. Welcome. Here you will find support and understanding.[28]

At this and similar sites, an ideology of support and illness replaces one of volition and control.

Despite these debates over pro-ana identity, content shared across pro-ana sites is remarkably similar. Most websites include some form of "Ana's Religion," including the Ana Creed, the Ana Psalm, the Ana Commandments and Ana Prayer, religious references clearly modelled after Christian religious doctrine. At the opening of this chapter, for instance, the Ana Creed finishes with the affirmation: "I believe in a wholely [sic] black and white world, the losing of weight, recrimination for sins, the abnegation of the body, and a life ever fasting."[29] Similarly, the Ana or "Thin" Commandments intone: "if you aren't thin, you aren't attractive"; "being thin is more important than being healthy"; and, "being thin and not eating are signs of true will power and success."[30] The Ana Psalm borrows liberally from the twenty-third psalm of the Christian Bible:

> Strict is my diet. I must not want. It maketh me to lie down at night hungry. It leadeth me past the confectioners. It trieth my willpower. It leadeth me in the paths of alteration for my figure's sake. Yea, though I walk through the aisles of the pastry department, I will buy no sweet rolls for they are fattening. The cakes and the pies, they tempt me. Before me a table is set with green beans and lettuce. I filleth my stomach with liquids, my day's quota runneth over. Surely calorie and weight charts will follow me all the days of my life. And I will dwell in the fear of the scales forever.[31]

Allusions to religious piety, sin, guilt and shame combine with contemporary adages that express the cultural valuing of the thin feminine aesthetic above all else, thereby aligning a commitment to thinness with a commitment to religious faith.

Despite the often facetious tone of this religious framing, the intent of pro-ana websites is strikingly serious and the volume of detailed weight loss methods is staggering. At "Anorexic Nation," for instance, more than one hundred individual techniques or practices for weight loss are listed.[32] With multiple pro-ana sites interlinked online, thousands of weight loss techniques can be accessed through cross-site links. Such techniques tend to be organized in several main categories. "Tips and tricks" for weight loss at "Anorexic Nation" include drinking vinegar before eating, eating only when alone, or only consuming fluids, while "The House of ED" offers the following tips: purge in the shower (so people will be less suspicious); "whenever you get hungry, think of all the people who made fun of you in [junior] high"; and, "don't swallow! Take a bite, chew, and spit it out."[33] Lists of good and bad foods are also popular—and extensive—on pro-ana sites. For example, "AnOreXic AdDiCt" lists sixty-three "safe foods," organized by category (liquids, proteins, dairy, fruits, vegetables, grains and miscellaneous [condiments, sugar-free gum and candy]), as well as identifying over ninety "negative calorie foods" (foods which take more calories to eat than they contain).[34] "Chaotic Serenity" details safe food selections for eating out, as well as extensively discussing the role of various foods, minerals, and vitamins in the management of hypoglycemia (or low blood sugar, a common side effect of severe food restriction).[35] Further combining dietary data with pro-anorexic food restriction, the "Living With Ana" site catalogues "disgusting food"—foods put together in "nauseating combinations" to reduce consumption—such as jello sushi, sausage milkshakes and Brussels sprout tapioca pudding.[36] Over the counter and herbal appetite suppressants, laxatives and diuretics, and various drugs (legal and illegal) that induce weight loss are also frequently discussed.[37]

On most pro-ana sites, diets receive special attention, as do fasting techniques. "Cerulean Butterfly" offers the frequently cited 2-4-6-8 Plan, the 3-Day Diet, and the Cabbage Soup Diet Plan[38]; and, "A Walking Barbie" outlines no less than twenty-five plans, including the "Ice Cube Diet" (eating ice cubes by various methods and at varying temperatures to produce a one-pound weight loss), the "Marya Hornbacher Diet" (a 202 calorie per day diet named in honour of the former anorexic/bulimic and author of *Wasted*[39]), and "Karen Carpenter's Lemon Fetish" (modelled after famous anorexic Karen Carpenter's apparent obsession with adding lemon juice to all meals and beverages to act as a diuretic).[40] Similarly, "Anorexic Nation,"[41] "Victoria's Pro-Ana Journal,"[42] and others provide extensive scientific discussion of fasting and its physiological effects, along with detailed fasting plans. Tools for calculating and tracking calorie intake, weight, measurements, body mass index (BMI), and basal metabolic rate (BMR) are also included on many websites.[43] Throughout these sites, nutritional data, medical guidelines, and mainstream diet discourse are co-opted for uses other than they were originally intended.

Exercise does not receive this near obsessive treatment on most pro-ana webpages. And, only some websites include internal links dedicated to exercise.[44] More commonly, exercise regimes are included in the extensive pro-ana listings of "tips and tricks." Although it has its place, the pro-ana response to exercise is cautious. As "Cerulean Butterfly" states, "I hate having muscles; they make me look bigger than I want to be. But muscles also take a lot of calories to maintain—once you get buff, your body burns more calories keeping you that way than if you were just boney."[45]

Along with such material, "triggers" are a central element of pro-ana sites, a "trigger" being any material which motivates an individual to start losing weight or to keep losing weight. Often referred to as "thinspiration," lists of trigger books, movies, and quotes are common,[46] as are thinspiration images and statistics. Most trigger images are copied—often without acknowledgments or copyright data—from other online sources. "Ana/mia artwork" is sometimes produced by pro-anas themselves, but more often employs mainstream material as thinspiration. For instance, an *Adbusters* image, which deliberately conflates Calvin Klein's Obsession perfume campaign with bulimia, is included on one pro-anorexia site (see Figure 2).[47] Such illegally copied and manipulated media images sit beside disturbingly self-expressive artwork which reflects the pain of the pro-anorexic experience.

"Hardcore bone" images (images of severely emaciated women) and "reverse triggers" (often near-pornographic images of obese women) represent the extremes of thinspiration. While "bone" images tend to be uncaptioned—as if they speak for themselves, reverse triggers seem to require additional interpretation with derogatory comments often captioning these particular images. For example, at "Ana's Underground Grotto," one reverse trigger image of a reclining, scantily clad obese woman is captioned "couch surfing like a beached whale."[48] Mediating this derision slightly, the preface to its "Reverse Triggers" page states, "these images represent what we never want to become. If you want to know why . . . just look around you at how these people too often end up being treated. Perhaps you yourself have been guilty of this at times. For the record, this site does not condone bashing fat people. We just choose not to be among their number, is all."[49] On the other end of the spectrum, "Victoria's Pro-Ana Journal" provides images of extremely skeletal women as thinspiration, including the popular pro-ana "Bony Pink" (see Figure 3) and numerous anonymous women (see, for example, Figure 4). However, following other online caveats that suggest such images are doctored, "Victoria" states: "I think these pictures are disgusting but some people might find them useful. I definitely believe there is a difference between being ana and being anorexic."[50]

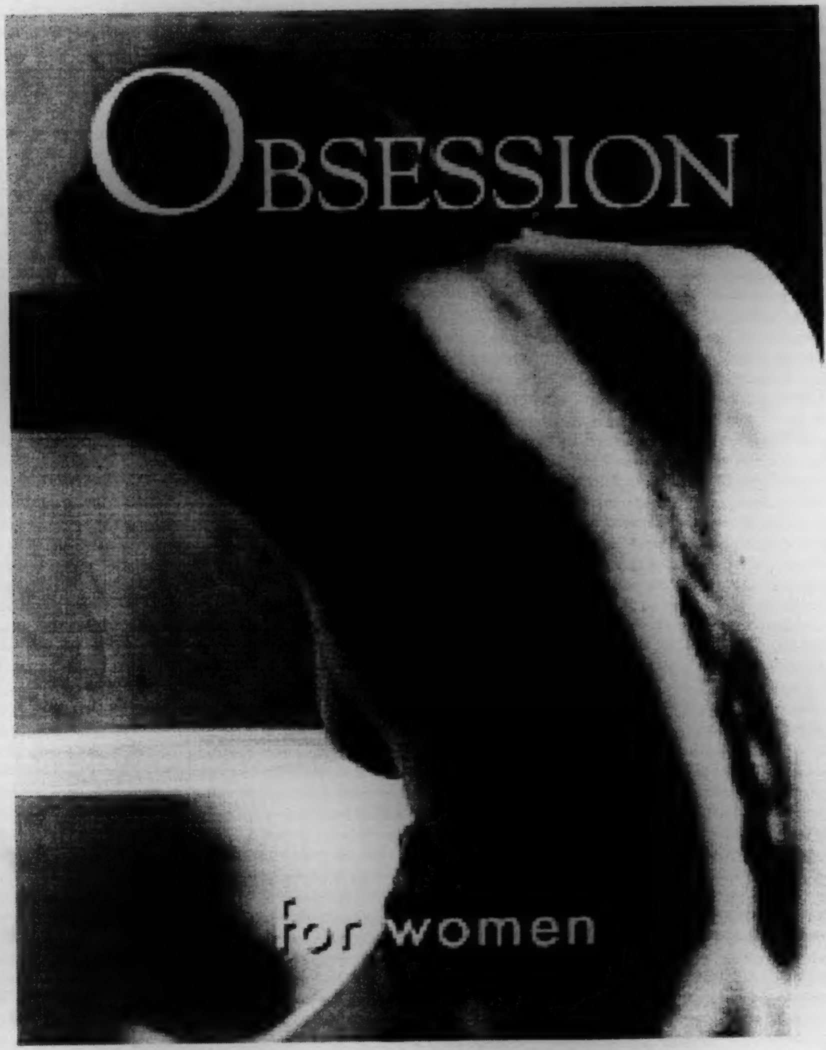
OBSESSION
for women

Figure 2. The *Adbusters* spoof of Calvin Klein's "Obsession" campaign, included as "thinspiration" on a pro-anorexia site. Courtesy of www.adbusters.org.[51]

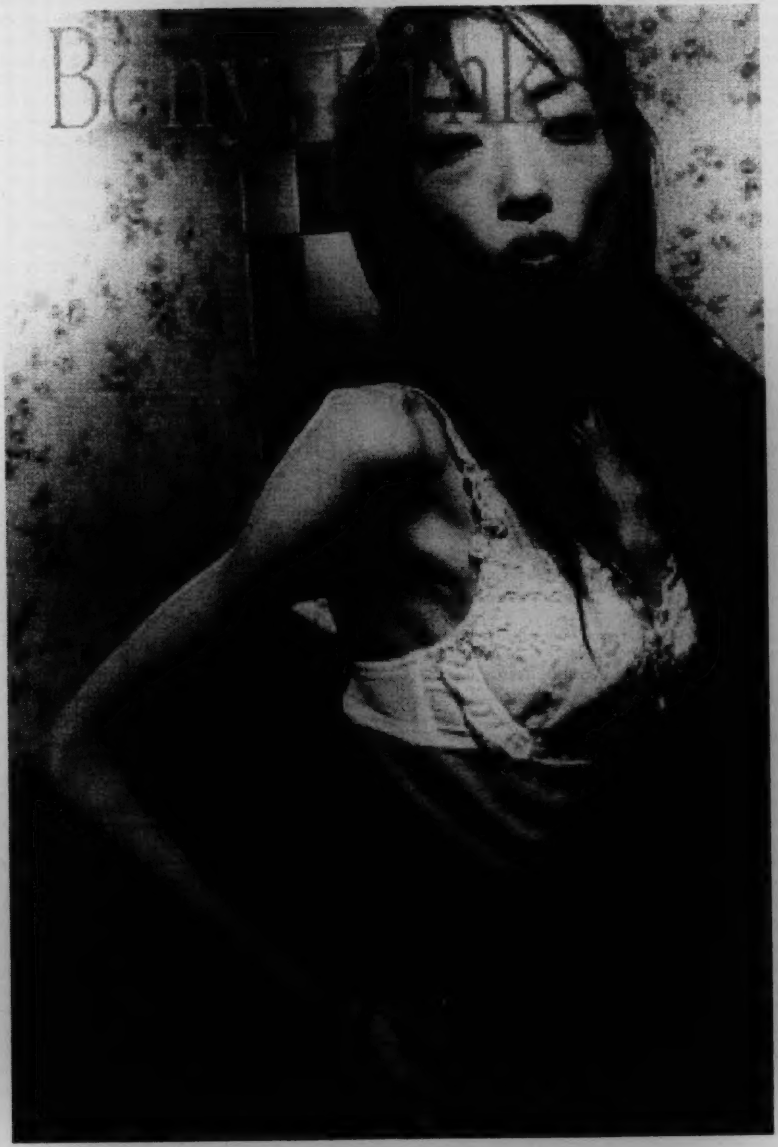

Figure 3. This image of pro-ana "Bony Pink" is presented as "hardcore bone" inspiration on a pro-anorexia website.[52]

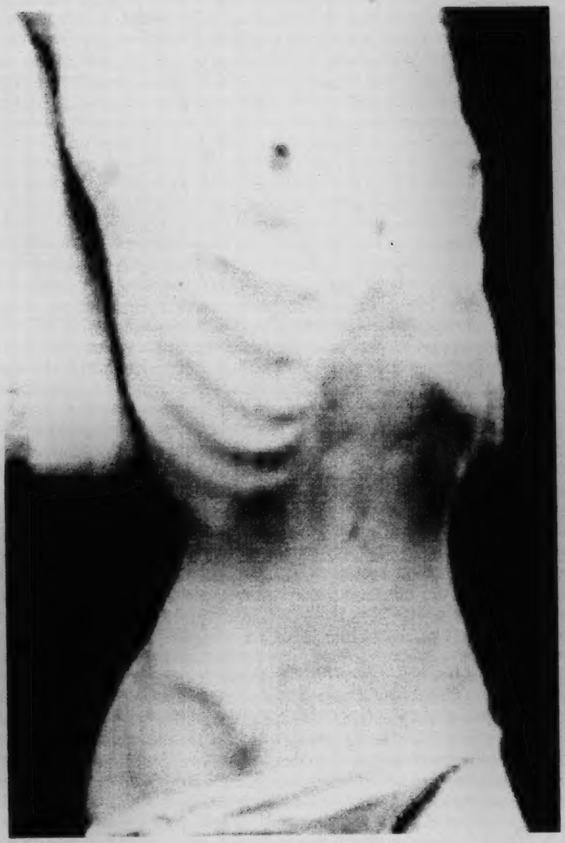

Figure 4. “Bone Thinspiration” image of an unnamed woman on a pro-anorexia website.[53]

Most popular, however, is thinspiration via celebrities and models. Reflecting typical celebrity inspiration, for instance, “Wasted Shadow” lists the height, weight and body mass index (BMI) of twenty-six popular celebrities,[54] along with images ranging from actress Lara Flynn Boyle and model Giselle to Nicole Kidman and Calista Flockhart.[55] Taking a slightly different approach, “A Walking Barbie” gives special attention to “society” celebrity Paris Hilton throughout its site, posting her image on its homepage, as well as detailing the "Paris Hilton" diet and exercise regimes. Although celebrities such as "Posh Spice" Victoria Beckham and pop star Britney Spears are also discussed, "Walking Barbie" implicitly presents Paris Hilton as its icon of perfection.[56] In a different twist on celebrity thinspiration, "Ana's Heaven" "outs" celebrities whom it associates with disordered eating, as well as offering images of what other celebrities would look like if they were "ana."[57] Beyond this kind of focussed thinspiration, images of celebrities and models are scattered throughout most pro-ana sites, making the ideal images of pro-anorexia ever-present.

A final core element of pro-ana sites is some form of personal exchange.[58] Chatrooms, discussion boards and journaling feature in many sites, with some sites devoted extensively to blogs, diary-rings, poetry, and other forms of narrative self-expression about pro-anorexia. These chatrooms and message boards are somewhat different from the main areas of the sites. They do involve near obsessive discussion of weight loss practices, but they also clearly demonstrate the pain and frustration of individuals. Forums on anorexia, self-injury ("any form of self-injury may be discussed"), Ed-nos (eating disorders not otherwise specified), poetry, thinspiration, fasting, and parenthood fill one site,[59] while another has offerings as diverse as "anti-anas," "weigh-ins," "suicide," "abuse," and "recovery."[60] Whether seen as defiant or disturbed, each post to these forums invokes the "ana" identity through detailed accounts of daily practices, shared tips and tricks, support, "religion," and thinspiration.

With its location on the largely unpoliced internet and its advocacy of eating disorders, it is not surprising that the pro-anorexia movement has become highly contested. Protests have arisen from child educators and advocates, parent groups, and medical agencies. These groups jointly object to the teaching and advocating of disordered eating, because they believe it causes harm. Their protests have taken various forms. For instance, the lobbying of internet service providers through email and letter writing campaigns has been accompanied by online anti-pro-ana campaigns.[61] In fact, the National Association of Anorexia Nervosa and Associated Disorders (ANAD) thanks internet service providers Yahoo!, ivillage, aol, MSN, and Homestead Technologies on its website for honouring their "terms of service" by removing offending pro-anorexia websites. The ANAD site states that "thousands of parents, aunts, uncles, brothers and sisters, friends and recovered victims of an eating disorder also express their gratefulness to you for protecting minors and for not hiding behind anything when asked to honor your TOS [terms of service]. Your strong integrity reflects your commitment to your members and advertisers."[62] ANAD also operates a "Media and Internet Guardian" program, comprised of "people, including young people, worldwide who volunteer to watch the Internet and media – and then contact ANAD about the negative body image or potentially dangerous eating disorders Websites and advertising campaigns they discover."[63] Many concerned groups and individuals have also established pro-recovery and counter-pro-ana websites, which surface in internet searches for pro-ana material.[64] And, more subversively, anti-pro-ana individuals enter pro-ana sites and chat rooms to challenge the merits of pro-anorexia as a lifestyle. As evidenced by statements on pro-ana sites, such protests are often as contentious as the material which they condemn.

Internet service providers have responded to these concerns in a number of ways. Following intense public pressure from ANAD and others, Yahoo was the first to ban pro-anorexia websites in the summer of 2001.[65] Indeed, when entering many pro-ana links, "account suspension" notices are now common, as are blocked and re-routed webpages.[66] Some providers have taken less extreme measures, by simply attaching pop-up boxes and banners to pro-ana sites which offer information on treatment programs or include warnings that site content could cause harm. Similarly, legal warnings about prohibited content are now standard on some pro-ana sites, much like the warnings attached to internet pornography. In the American context especially, these warnings likely serve to protect internet service providers from legal liability more than they serve as a deterrent against participation. Most pro-anorexia sites are free, with entry into only certain chatrooms or message boards requiring membership or sign-in. However, not all service providers are as concerned; many pro-ana sites also include bannered and/or pop-up advertisements for diet pills, exercise programs, and herbal supplements designed to melt away the pounds. For example, the pro-ana site "The Skinny" includes an advertising banner for Phentermine, a weight loss pill sold over the internet.[67] Similar advertisements offering "healthy eating," "lose 9 pounds every 11 days," and "your perfect diet" parallel pro-ana content more than they warn of its dangers.[68]

Despite these measures, pro-anorexia websites disappear only to reappear in new form. While some webmistresses simply rename or relocate their sites, others link their sites to more "legitimate" sites on diet and health. Connections to sites on monastic and religious fasting, body cleansing, meditation and dieting are, in fact, common.[69] Web-rings cataloguing pro-anorexia sites have also increased in popularity, perhaps evading the censure of pro-anorexia material on the internet.[70] And, "pro" pro-ana campaigns have also been established to counter those who reject them, the symbol of which has become the "pro" pro-ana ribbon (see Figure 1, above). Online petitions are common,[71] and the public furor over pro-ana has likely prompted, or at least intensified, a shift of pro-ana into the "real world." While a handful of pro-anas have extended their participation through media reports and talk shows,[72] most express their support more subtly. Pro-ana "solidarity" bracelets mark a shared, but still secretive, belonging, symbolically representing the practices of their wearers—red for anorexia, purple for bulimia, black and blue for "SI" (self-injury).[73] T-shirts and ballcaps support "the cause," as well, with slogans like "No Footprints" and "Ana to the Bone" more defiantly calling out to others.[74]

Despite these more conventional signs of solidarity, pro-anorexia flourishes largely only in cyberspace. Many pro-anas have simply redeveloped their sites in response to protests, with home pages which include little or no explicit pro-ana content and warnings not to enter or participate if you are not "like minded." For instance, "Wasted Shadow" cautions: "This is a pro-ana site, if you do not have an eating disorder then please leave! If you're in recovery then well done, I wish I had your courage. You should probably leave too though I do not want to be responsible for bringing anyone back down into this hell I'm living in. If you do have an eating disorder then you are very welcome here. I hope you find support here and somewhere where you will not be judged! Could people please stop sending me nasty emails. Do your research before you criticise something you don't understand!"[75] Taking this further, some sites include explicit warnings not to participate on the site if you are anti-pro-ana. "Beautiful Perfection" warns: "i swear to god, i had better not find anyone in here harrasing [sic] anyone…or i will hurt some people."[76]

Similarly, at "Cerulean Butterfly," one encounters the following series of warning messages even before the page opens, enclosed in warning pop-up boxes:

> *Message 1:* Caution: this site contains pro-Eating Disorder images and information. If you do not have an eating disorder or are in recovery, do not enter this site.
>
> *Message 2:* Seriously. You enter this site of your own volition, and I am not responsible for the decisions you make based on the information you see here.
>
> *Message 3:* So don't send me hate mail. It's your fault if you don't like what you see.

After "ok-ing" these caution messages, you enter Cerulean Butterfly's homepage—a header banner with the image of an anime waif declares "50,000 hits – thank you!," while the pro-ana maxim "quod me nutrit, me destruit" (what nourishes me, destroys me) flanks a Cerulean butterfly.[77]

A number of websites present a less polarized response to the pro-anorexia movement. Run predominantly by former anorexic women, these sites extend the ideology of support offered by some pro-anas, arguing that they understand the difficulties faced by pro-anorexic individuals. This approach acknowledges the struggles of anorexic practice, as well as the rejection—and sometimes outright harassment—experienced by pro-anas (see, for example, Figure 5). Despite offering a "safe space," though, some pro-ana support sites clearly express their politics, articulating their disgust with anorexic practices (see, for example, Figure 6). For the most part, the underlying message is one of recovery, although recovery when the individual is ready.

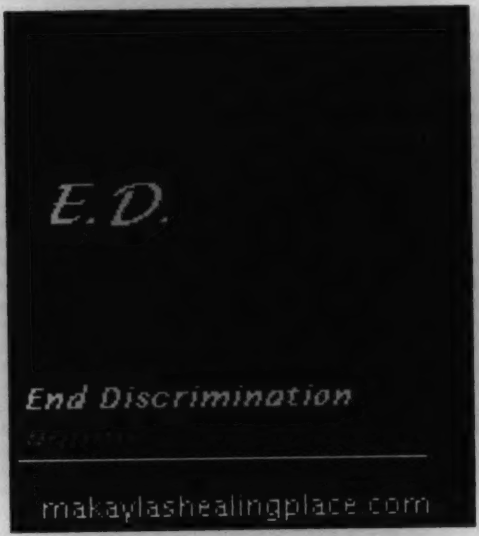

Figure 5. Online banner supporting tolerance of and support toward pro-anorexia.[78]

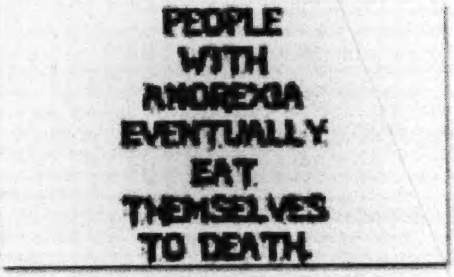

Figure 6. "Anorexia – Cannibalism" sticker available through a pro-ana support website.[79]

Reading Pro-ana Discourse

> *Through prayer, fasting and meditation I will drop below one hundred pounds, the despicable three digits. I want to be ninety-nine or nothing. Want. Did I say want? I shouldn't say want. I shouldn't say shouldn't. You're confused? . . . . I'm trying to eliminate my ego but that action is ego itself. All action is ego. Are you following me? I'm not here with my mirror and scale for the good of my health.*

From *'Tis: A Memoir* by Frank McCourt,
quoted on a pro-anorexia website[80]

“*@ the Doctor’s Office*”[81]

The intense public furor over pro-anorexia hinges on the status of anorexia as a disease. Seen as blatantly dangerous by many, pro-anas are rejected for refusing the dominant medicalized interpretation of disordered eating—that anorexia nervosa, bulimia nervosa, and other eating related disorders are illnesses that need to be cured. While pro-anas themselves debate the meaning of their identity and sometimes take up a “disease discourse,” the public backlash against them centres on their specific use and interpretation of “anorexia.” To those within the pro-anorexia movement, “anorexia as disease” morphs into “ana” as identity and lifestyle, religion and practice, cutting through the rhetoric of “health” that is tied to the thin aesthetic. “Ana” is resignified beyond its diagnostic labelling in the doctor’s office. To those against pro-anorexia, such interpretations precisely point out the diseased state of individuals involved with the movement. Despite these differences, pro-anorexia is intimately entwined with the medical discourse on anorexia, appropriating its terms for other purposes but never quite escaping its punitive force.

This force begins with the medical logic of pathologization. As outlined in Chapter 1, Michel Foucault describes the discursive expression of modern medical epistemology as the separation of that which is pathological from that which is normal. The medical gaze—and, specifically, the anatomo-clinical gaze—mediates this process of pathologization. The trained eye of the physician is turned upon the individual. If pathology is detected, the individual becomes a medical object; and, once a medical object, the individual is drawn into the realm of medical control.[82] The silent, observed body reveals its disease under the medical gaze and within the imbalanced exchange of the clinical moment, discursively positioning the individual as a passive object for medical control.

This gaze materializes medicine's authority over normalized (and normalizing) understandings of the body through diagnostic criteria. For "anorexia nervosa," these criteria include: "an intense fear of gaining weight or of becoming fat," even though one is underweight; refusal to maintain a normal body weight for age and height; a body mass equal to or less than 17.5; a disturbance in one's perception of body weight, size, or shape; denial of the seriousness of one's current body weight; and, amenorrhoea (no menstrual period) for at least three consecutive months.[83] The legitimized authority to determine whether an individual meets these criteria rests solely with the physician. If met, the diagnostic label of anorexia nervosa is applied to the individual, initiating medical objectification.

With anorexia (and other feminized disorders), however, the diagnostic process is layered with socio-historical and sociocultural hierarchies. Illustrating the collusion of medicine and patriarchy, medical epistemology draws on the Enlightenment's masculinist construction of the ideal individual, as discussed in Chapter 1. Specifically, this merging produces a normative prescription for the "model man" by which medical authority extends across the realms of "health" and morality, individual and social relations, the normal and the pathological.[84]

The medical gaze is thus not only diagnostic, but also disciplinary, charged with extending "*the medical bipolarity of the normal and the pathological*" to all of social life.[85] In attending to the "normative posture" of society, medicine implicitly positions "woman" as the unhealthy, abject foil to its model man. Discursively pathologized, woman's unruly body and irrational mind then warrant her containment via masculinized medicine: medicine's self-given authority over the female body harnesses the Cartesian positioning of woman as a passive—yet irrational—body-object.[86]

Similar power-laden knowledges are entwined with the particular contemporized medical discourse of anorexia, exposing the cultural convergence of health and beauty.[87] Susan Bordo, for instance, suggests that anorexia crystallizes our cultural ills, "from our historical heritage of disdain for the body, to our modern fear of loss of control over our future, to the disquieting meaning of contemporary beauty ideals in an era of greater female presence and power than ever before."[88] And, Helen Malson argues that anorexia nervosa must be understood "as a multiply produced object of discourse and as a category that is particularly relevant to women, to the (discursive) constitution and regulation of femininities, subjectivities and the *female* body."[89] Mervat Nasser, for example, highlights the emergence of eating disorders in non-Western cultures as a cultural symptom of the globally changing demand for particular female bodies[90]; and, Becky W. Thompson reveals how the eating problems of often "invisiblized" women—women of colour, lesbian women, poor women—serve as coping mechanisms by which to mediate the traumas wrought from their particular disempowered identities.[91]

As a power/knowledge apparatus, however, medical epistemology erases these social and cultural realities. While many examples illustrate that medical practice is beginning to acknowledge the needs and concerns of the individual in its treatment of disordered eating,[92] it still discursively draws on the long historical thread of women's passification and objectification. The disciplining of the anorexic patient to medical standards of treatment and recovery mirrors the historical constraining of women's bodies, identities and voices. Extending Foucault's disciplinary panopticism, the dominant medical approach to disordered eating employs techniques of routinization and surveillance in treatment to produce appropriately disciplined feminine bodies.[93] And, the uni-directional, hierarchical structure of traditional treatment protocols generates what Robin Sesan calls "the oppressive nature of inpatient [treatment] settings, which all too often replicate destructive patriarchal patterns."[94] Helen Gremillion goes further, arguing that standard treatments not only replicate but also exacerbate the particular sociocultural conflicts experienced by women with eating disorders: "when psychiatric discourse mystifies the social shaping of bodies and persons through medical objectification, it also crystallizes certain ideas and practices that are designed to create fit and healthy bodies (and that, ironically, patients can use to support their anorexia)."[95] The activity of treatment requires a return to the "docility" of normative femininity.

Yet, this feminized passivity is coupled with an active irrationality, a sense of uncontained power and movement which needs to be tamed—quarantined. In the dominant discourse, the pathology of illness and the out-of-control woman merge in pro-anorexia, reproducing the rationale for medical control over women's bodies. Contrary to the medical passification of the anorexic patient, though, pro-anas seem fervently aware of their practices, even if this awareness is fraught with contradictions.[96] Though arguably disciplining themselves to the standards of society, participants in the movement reject the constraint of medical intervention upon their identity. Their public voice also violates the medical authority over their "disease": pro-anas have not been granted the legitimacy to speak about their embodied practices. By contrast, medical objectification denies the possibility of a pro-anorexic voice by discursively de-subjectifying its patients: these are ill women needing to be cured; any voice derived from anorexia is a further expression of this illness. While pro-anas turn to the pseudo-public realm of cyberspace to find support, "occupying public spaces and revealing one's abnormality or deviance is considered equally if not more unhealthy."[97] Therefore, pro-anorexia violates the terms of the medical construction of anorexia: its participants refuse the passive objectification demanded by medical epistemology.

Still, anorexia retrieves its meaning from medicine and pro-anorexic discourse distends this meaning. Pro-anorexia is inextricably caught up with medical logic. It cannot fully escape medical authority as it attempts to resignify its punitive force. Instead, the movement appropriates the terms of this discourse in order to elude its hegemonic power. Contrary to the perspective that anorexics are not fully cognizant of their practices, pro-anorexia suggests that the dominant medical discourse of anorexia is central to "ana" identity. Through the appropriation of medical knowledge, pro-anorexic discourse intervenes in and usurps the traditional authority wielded in the clinic of the doctor's office. It establishes a literal, though virtual, clinic that seeks to manipulate the pattern of gaze-diagnosis-treatment in order to teach individuals how to produce a "normal" body. In relation to the postmodern cultural clinic, it deliberately displaces the clinical moment, thereby disrupting the non-reciprocal exchange upon which medical intervention is based.

Pro-ana websites materialize postmodern clinical space by, first, framing their practices in a rhetoric of science, physiology and health. Many sites detail the specific diagnoses of anorexia nervosa, bulimia nervosa and other "eating disorders," although this data is often included with little explanation.[98] Following "diagnosis," pro-anorexic discourse treats its self-imposed symptomology. The "Medicine Cabinet" at the "House of Ana," for instance, suggests taking women's multivitamins to replace the minerals and vitamins lost through excessive exercise and lack of food, Eno to treat cramping, Advil Migraine for the body pain that anorexic practices produce, and aspirin—not for pain, but to speed up the metabolism.[99] A message of evasion is implied; diagnostic data will pre-empt diagnosis, vitamins and "meds" will mask symptoms.

While some sites address the negative side effects of anorexic practices, others couple self-control and discipline with physiology and health in pursuit of the thin aesthetic, mirroring the contemporary infiltration of this aesthetic by the medical standards of health. For example, "Victoria's Pro-Ana Journal" extensively discusses the physiology of fasting, including material on ketosis (the conversion of fat to fuel) and the catabolization of amino acids in muscle tissue. With proper fasting technique, for instance, one will achieve increased energy levels, elevated growth hormones and ketone bodies, improved mental clarity, a more youthful appearance, and overall improvement in health. Despite warning that "severely restrictive diets are extremely unhealthy, in many cases, even life threatening," "Victoria" asserts: "eliminating food (during the fasting period), one of life's greatest pleasures, is not easy for most! However, those that have the discipline, and determination [will] have tremendous to extreme healthy benefits awaiting them!"[100] And, as the "House of Ana" states, "if you're gonna be Anorexic, be as healthy as possible."[101]

This appropriation of medical knowledge is most exemplified, however, by explicit pro-ana discussions of how to deceive the physician. Such discussions assume the prior identification of "diseased" status or, at least, acknowledge that pro-anorexic practices put an individual "at risk"—whether at risk of illness or of being discovered is often not clear. For example, while "Cerulean Butterfly" acknowledges that "very few things scare me more than my WEEKLY visit to the doctor," she offers a range of tips for avoiding detection at the doctor's office, all of which focus on disguising the physiological symptoms of disordered eating.[102] Paralleling physicians' concerns about anorexic patients "overloading" before weigh-ins,[103] some tips suggest ways to increase one's weight temporarily: "drink a lot of water before you go" (although this technique may skew a urinalysis and reveal what you've done); wear heavy clothing; and, put coins in your underwear. Complain of a recent sore throat to disguise the throat irritation left from purging. Dress warmly to increase body temperature temporarily, shave off any lanugo (fine body hair which develops due to severe weight loss) before the appointment, ingest salt to increase blood pressure, and "practice meditation to control your heartrate." Finally, if none of this works and your doctor confronts you, "tell him/her you want this to be kept confidential. This is especially important if you're under 18, since some doctors will go ahead and tell your parents anyway…UNLESS YOU SAY OTHERWISE." However, these methods of deceit are dubious. While Cerulean Butterfly reveals her own regular monitoring by a physician, she also states that her doctor is "way [too] damn smart to let me get away with any of [the] stuff I'm about to tell you to do. These tips pretty much only work if your doc doesn't know about your eating disorder." Provided the physician does not "know," then, the medical gaze may be tricked into seeing a "normal" body, as signified by the quantifications of weight, temperature, heart rate and urinalysis.

Manipulating this gaze is paramount to the "space" of this pro-ana clinic. On the one hand, the gaze is the explicit mechanism of pathologization, initiating diagnosis. Thus, diagnosis—and, hence, the medical gaze—is a potential threat to "ana" identity. On the other hand, when the legitimized medical gaze of the physician is explicitly manipulated by pro-anas, it becomes a means of evading detection and preserving their identity. Pro-anas first appropriate the gaze to imagine its power. Once imagined, they manipulate the litany of symptoms it is trained to identify. And, once manipulated, they pre-empt its diagnostic power. This appropriation of medical power disrupts the hegemonic medicalized discourse on anorexia, thereby resignifying "anorexia" through the identity of "pro-ana."

Paradoxically, this appropriation enables the potential normalization of pro-anorexia: escaping the medical gaze of the physician pre-empts pathologization; and, by its absence, lack of pathology prompts normalization, linking pro-anorexic discourse back to the larger social project of medical epistemology. In turn, normalization frees pro-anas from the body-object status of medical epistemology, thus reasserting their embodied subjectivity. Certainly, the disciplinary gaze of other individuals also threatens pro-ana identity—that of parents, friends and teachers who question the changing behaviour and bodies of pro-anas. And, pro-anas also "hide their friend"[104] from these individuals: wake up late (or leave early), so you don't have to face family meals; hide weights in your clothing and offer to weigh yourself in front of those expressing concern; simply say you've already eaten, or aren't hungry, or are a vegan; or, "just say 'no' (it's easier than you think)."[105] In fact, medical authority is used in this deception as well: you're just getting over the flu and the "doctor said to only drink fluids for a while"; a medically prescribed change in medication is "screwing" with your appetite; and, of course, "say you're ill, simple but effective."[106] The irony, of course, is that this deceitful illness is acceptable where anorexia itself is not. While thwarting the concern of others may temporarily sustain pro-ana identity, it is still only the legitimized gaze of the medical clinic that holds the authority to diagnose anorexia; and, it is this particular gaze to which other individuals turn for reassurance. If this gaze and its punitive impetus are manipulated, the pro-anorexic body, and individual, will be read as normal, thereby silencing concerns raised elsewhere. Virtual space thus becomes clinical space in which the evasion of multiple disciplinary gazes is enabled.

Yet, this evasion implicitly acknowledges the abnormality of pro-anorexia, again linking it to the dominant discourse of anorexia. While manipulation of medical knowledge outside its usual clinical space produces the conditions by which pro-anas may be able to unseat medical control over their bodies, they do so precisely because of medical authority over their "disease": pro-anorexic individuals know they are seen as abnormal. Their breach of medical authority, therefore, works only so long as it is not detected. If detected by the medical gaze, they are again brought into the regulatory space of the clinical moment, but with the additional label of deviance added to their diseased state. No longer just the diagnostic standards of weight loss, denial and amenorrhoea, anorexic pathology is then additionally produced through the "irrationality" of pro-anas, as evidenced by their deception of the physician, their appropriation of the gaze, their usurpation of medical knowledge for other ends. Pro-anorexic discourse thereby instigates the renewed terms of its own pathologization and, in turn, dismissal as "sick"—sick being at once ill and disgusting: disgust at the "thought" of pro-ana, disgust at the content of the websites, disgust at the anorexic body itself.[107]

And, in a final blow to medical logic, pro-anas take this doubled pathologization to its extreme—only death is good enough. With mortality rates higher than for any other psychiatric illness, research suggests that between 5 and 20 percent of anorexic individuals die from their practices.[108] This risk, however, is of little consequence to some participants. “AnOreXic AdDiCt” writes:

> A lot of people in the guestbook ask me and other pro-rexies if they realize that they can die from anorexia. i don’t know about anyone else, but i do in fact realize that. in fact, i don’t really care. if i died tomorrow, so be it. my life doesn’t really mean that much to me, so if you want to tell me that i’m stupid because i don’t realize that i could possibly die from anorexia, [that’s] just fine with me.[109]

No rhetoric of health and wellness, or even self-preservation, intervenes in this single-minded pursuit of thinness.

"Wanting to be Normal"

"BlueDragonfly" does not want others to interfere with her anorexic efforts. Unlike many pro-anas, though, she does not conceive pro-anorexia as a lifestyle choice, or a fad diet, or a means of teaching others to be anorexic. Instead, she writes:

> We have a way of being able to bare our souls to each other because we don't need to hide the most basic part of our mental makeup. It is a starting point: we all know where each other are coming from, we don't need to explain that, and we can trust each other more than anyone else in our worlds . . . .
>
> You're not okay, and that's okay. You can come here and try to find a bit of comfort in knowing that you're not alone, won't be judged and no one is going to tell you to fix yourself. You'll do that on your own when you're ready. And we will support you in that decision as well.
>
> Because that takes the most strength of all: Wanting to be normal.[110]

Beneath this statement sits the pro-ana mantra "Nothing tastes as good as thin feels. Period."

Yet, "wanting to be normal" implies a return to "health." Despite the mainstream revulsion toward pro-anorexia, then, it is not only pathology and disgust which are at play in this discourse. In the terms of the postmodern cultural clinic, the medical discourse of "health" collides with the thin feminine aesthetic sought by pro-anas as that which they are judged to have abandoned and—

possibly—the elusive foil to their practices. Outside pro-anorexic discourse, the thin aesthetic is already infused with the impetus of health in our culture, strengthening its force with the weight of medical authority. Regular exercise will decrease women's risk of breast cancer, diabetes and other diseases, as will maintaining an ideal weight.[111] The contemporary trend of healthism itself idealizes "appropriate weight" through the Quetelet (or Body Mass) Index, coding thinness with a sense of self-care and responsibility reminiscent of the virtue applied to the Enlightenment mastery over the body. Yet, as the thin aesthetic is also upheld as the contemporary marker of feminine beauty, the feminized disciplines of beauty and health are now inextricably entwined.

"Wanting to be normal," if even only as an imagined future possibility, also aligns pro-anorexia within a particular culturally normative discourse, albeit a troubling one. Embedded in women's multiplicitous experiences of normative femininity is the overwhelmingly common experience of bodily dissatisfaction. Eighty percent of women are dieting at any given time,[112] and eighty percent of women are also dissatisfied with their bodies.[113] More focussed research suggests the specificities of this dissatisfaction: regardless of their size, many women note a marked gap between their current and ideal weights, preferring a thinner figure[114]; the majority of women are "concerned about weight gain, body image, and eating behaviour during pregnancy"[115]; and, as women's perceived body weight and feelings of "fatness" increase, their body satisfaction decreases.[116] This research reflects the cultural obsession with bodily perfection, as idealized for women by the thin feminine aesthetic. In the inevitable absence of perfection, dissatisfaction becomes the "normal" experience.

In turn, this dissatisfaction feeds the disciplinary apparatus of normative femininity. Following Foucault, feminist scholarship has now exposed femininity as an ongoing process of disciplinary normalization. The individual incorporates the social demand for particular kinds of body-subjects, producing at once individual conformity and broader social control. Individual disciplinary practices—the micro-physics of power, the technologies of the individual—reproduce the "subjected and practised bodies, 'docile' bodies" required by society.[117] Although responsibility for conformity is thus located firmly with the individual, its need is perpetually reiterated through the threat of the (in)visible social gaze, through the ever-present threat of surveillance—Foucault's panopticism.[118]

However, as discussed in Chapter 1, the disciplinary standards for women's "subjected and practised bodies" are distinctly different from men's. This political anatomy must reproduce docile bodies that adhere to the asymmetries of the gender binary hierarchy, as well as of other power/knowledge apparatuses, thereby situating women's self-disciplinary practices within the constraints of multiple disciplinary regimes. Hence, Kim Chernin argues that women's struggles with body image and weight emerge in concert with a cultural discomfort over women's rising social power[119]; and, Honi Fern Haber suggests that normative feminine disciplines constitute the female body as distinctly submissive and weak.[120] Such feminized disciplines thus ensure both the diminishment of women's social power and the denigration of their bodies. As Susan Bordo writes,

> . . . women, as study after study shows, are spending more time on the management and discipline of our bodies than we have in a long, long time. In a decade marked by a reopening of the public arena to women, the intensification of such regimens appears diversionary and subverting. Through the pursuit of an ever-changing, homogenizing, elusive ideal of femininity—a pursuit without a terminus, requiring that women constantly attend to minute and often whimsical changes in fashion—female bodies become docile bodies—bodies whose forces and energies are habituated to external regulation, subjection, transformation, "improvement." Through the exacting and normalizing disciplines of diet, makeup, and dress—central organizing principles of time and space in the day of many women—we are rendered less socially oriented and more centripetally focused on self-modification. Through these disciplines, we continue to memorize on our bodies the feel and conviction of lack, of insufficiency, of never being good enough. At the farthest extremes, the practices of femininity may lead us to utter demoralization, debilitation, and death.[121]

This discipline then re-entrenches the historical construction of women as bodily-subjects—subjectified distinctly through their bodies, contradictorily unruly and passive at the same time—employing women's own daily practices to produce their embodied conformity. In Sandra Lee Bartky's words, "a tighter control of the [female] body has gained a new kind of hold over the mind."[122]

As a hallmark of disciplinary femininity, this control is rife with tensions, producing multiple elisions between the terms of its own production, as well as establishing the conditions for women's continued self-disciplining toward the muddled standards of normative femininity, which are themselves now expanded and refined by their fusion with medical rhetoric. Just as pro-anorexia challenges and reinforces its own pathologization, it also re-entrenches feminine norms while disrupting them.

One such tension is the collusion of disciplinary control with the contemporary ideology of individualism, locating the responsibility for producing such "docile" bodies—and, in turn, the blame for failing to do so—with the individual woman. While disciplinary normalization is perpetual, insinuating itself into every aspect of women's lives, the social message of individual responsibility is ever-present as well. Mainstream women's magazines materialize this message well, literally layering it onto revolving images of the feminine aesthetic, thereby becoming disciplinary texts. Standing in line at the grocery store checkout, for instance, a plethora of technologies are presented to the average woman, reminding her of the need to discipline her body. *Woman's World* swears "*You* can drop five pounds in a week!," [123] and *First* magazine declares "You, twenty-seven pounds slimmer in three weeks! Clinically proven!"[124] Similarly, *Us Weekly* touts the "Diets That Work! How Stars Get Skinny and Sexy for Summer,"[125] while *O: The Oprah Magazine* offers "the Non-Diet Diet."[126] Intensifying this message with the rhetoric of self-acceptance, an issue of *Chatelaine* subtitled "Love Your Body" [127] promises ten minutes to a flat belly and "Your Great Reasons for Losing Weight!,"[128] alongside articles about boosting one's self-esteem, loving one's body and "girl power."[129] Similarly, *Glow* features the beauty of inner strength,[130] but also offers ways to "look thinner instantly," have a "beach-ready body by next week," and achieve "perfect skin."[131] This contradictory advice is endless, renewed each week or month with a new crop of self-improvement promises. But, the paradoxical message remains the same: women must discipline their unacceptable bodies—through constant vigilance to diet, health, exercise, dress—but love them at the same time.

Contrary to its rejection as abnormal or disgusting, pro-anorexic discourse parallels, and often copies from, this mainstream message of bodily discipline and dissatisfaction, but without the reassuring message of self-love. Its idealized representations of the thin feminine aesthetic, which themselves prompt disciplinarity by invoking a "failure to measure up," are reproduced ad nauseum in near endless permutations of tips and tricks, celebrity thinspiration, and diet plans. As each website is shut down, another replaces it, reinvigorating the cycle of failure and self-discipline, just as new magazines show up at the checkout stand to suggest further techniques of normalization.

Yet, despite this coalescing of pro-anorexia and the mainstream message of disciplinarity, pro-anorexia is rejected as a non-normative expression of femininity and a violation of medical standards, its exaggeration of feminized discipline prompting a prohibitive reassertion of feminine norms. The boundaries of conformity are delineated only by the apparently grotesque application of their terms. Extending Susan Bordo's analysis of "feminized disorders," what pro-anorexia exposes is a hyperbolic text of femininity: "exaggerated, extremely literal, at times virtually caricatured presentations of the ruling feminine mystique. The bodies of disordered women in this way offer themselves as an aggressively graphic text for the interpreter—a text that insists, actually demands, that it be read as a cultural statement, a statement about gender."[132] With their bodies hidden in the virtual and anonymous space of the internet, pro-anas literalize this embodied text into tips and tricks, rules, and "commandments," their collective discourse writing the proscriptive of normative femininity and exposing its prescriptive disciplinary impetus as, not only an individual undertaking but also a mechanism of social control.

In this textualization, pro-anorexia extends the simultaneous rebellion and conformity of its anorexic precursor.[133] And, if it were not encompassed in the broader social framing of femininity, the pro-anorexic response to femininity would not require censure. Instead, its reiterative censuring—via pathologization and censorship—suggests that the particular disciplinarity of pro-anorexia is even more threatening to the social production of normative femininity. Pro-anorexic discourse and the disciplinary practices of its participants lay bare the multiple and contradictory constraints of contemporary femininity. It calls out the discomforting realities of the thin feminine aesthetic, thereby producing a broader social discomfort with its own content.

Although pro-anas are dismissed as disgusting, for instance, the coding of the thin aesthetic of a marker of feminine beauty is still relevant to pro-anorexia: dismissal signifies its exclusion from this standard. Yet, the presence of anorexic pornography on the internet suggests otherwise by displacing the dominant disgust prompted by the anorexic body with desire. With images mimicking the pro-anorexic "bone thinspiration" of extremely thin women, the text of anorexic porn sites parallels that of other cyber-pornography: sex for sale. And, however the desire for these particular thin bodies is constructed—as passive, as iconic, as controllable, as enticing—its elevation of the anorexic body to sex object elicits (pseudo)private desire out of public disgust.

Within the pro-anorexia movement, desire for the thin body is also reproduced: "thinspiration" images are not those of "ugly" women. Instead, the grotesque of pro-anorexic discourse is represented by "reverse triggers": the "fat girl" is called out as freak. Again displacing the revulsion it prompts, pro-anorexic discourse inverts this revulsion by situating disgust in obesity. The obvious irony is that obesity is derided by mainstream culture as well. Taking up this dominant perspective, pro-anas pursue the thin aesthetic, thereby reiterating its cultural value. Although pro-anorexic practices are not necessarily about "beauty," their iconic images—their thinspiration—reproduce the connection of beauty and desire. As with other women, pro-anas recognize the cultural message that thinness is beautiful, and that its achievement will be rewarded. This construction of desire folds in on itself, though, as "wanting to be normal" also implies disgust: pro-anas seek the desirable bodies they feel they lack, but are rejected for having the disgusting bodies they desire.

Read now through the broader rhetoric of health, however, the thin body is no longer solely about beauty. Its pursuit is reinforced through the impetus of health. But, if it is not only an aesthetic production, the thin feminine ideal serves alternate purposes. As pro-anas pursue an ideal held out to all women, their dismissal on the grounds of health becomes suspect. This is not to doubt the dangers of anorexic practices, but rather to suggest that the particular pro-anorexic pursuit of the thin aesthetic somehow threatens the power/knowledge apparatus of normative femininity.

Unsettling feminized conformity with its vocal demand for space and speech, pro-anorexic discourse prescribes bodies that are anything but "docile," in a traditional sense. Whether disdained as unacceptable or idealized as lissome, the iconic pro-anorexic body is epitomized by constant action, constant vigilance, constant discipline. On the one hand, this action suggests intense conformity—Foucault's docility. On the other hand, it exposes the production of docility, rather than just producing docile bodies.

In turn, this disruption challenges the norm which feeds feminized disciplinarity: the norm of women's bodily dissatisfaction. Perpetual dissatisfaction reiterates the discursive production of the out-of-control woman, marking her again (and again) as in need of discipline—both her own and the broader masculinized discipline of society—and re-establishing the conditions of her disciplinary angst. Since re-disciplining oneself to the elusive thin ideal ensures the reproduction of contemporary femininity, trying to rid oneself too readily of the normalized experience of bodily dissatisfaction threatens this discursively necessitated constitution of "woman." On the one hand, the fervent pro-anorexic pursuit of the thin aesthetic suggests a desire to end this perpetual cycle—although no end may be had. On the other hand, pro-anorexia so often refuses to resist the normative thrust of bodily of dissatisfaction, simultaneously embracing it to the exclusion of all else and resisting its punitive production of the silent, socially isolated woman. As an end to this vicious cycle of self-immolation is sought by all women, however, the implied possibility of its end evokes an uneasy but familiar feeling of recognition which must be contained in order to perpetuate the power/knowledge apparatus of normative femininity.

While pro-anas reflect a heightened awareness of bodily dissatisfaction, their single-minded pursuit of its prescriptive alternative—the ideal feminine aesthetic—suggests the impossible possibility of achieving the ideal and overcoming the norm of dissatisfaction. This paradox, in turn, prompts the realization that such an achievement, although discursively impossible, threatens normative femininity. While women's involvement with disciplinary femininity socially pacifies women, the adamant pursuit of femininity as solely about the achievement of the thin ideal exposes the mechanisms at play in a more broadly conceived feminine norm. When this pursuit overshadows women's attention to other aspects of femininity—the social and biological reproduction of the family, for instance—the thin aesthetic is exposed as representative of a broader femininity, one which encompasses other feminized roles, statuses, practices, behaviours—disciplines—which are necessary for the contemporary reproduction of the gender binary hierarchy. Although the idealized representation of femininity is being pursued, its productive outcome is being thwarted, whether through single-minded pursuit, social isolation, amenorrhoea or death. And, while pro-anorexia suggests subversive potential, it simultaneously reinforces women's social and physical docility. These women are not "attending" to other aspects of feminine identity, but they are attending too well to the thin aesthetic.

The thin aesthetic is thereby also revealed as a symbolic coding—a signifier—for the disciplinary force of normative femininity. And, pro-anorexia exposes the conflation of this disciplinarity with its idealized representation. Yet, by focussing on this signifier to the exclusion of its multiple significations, pro-anorexic discourse may momentarily unhinge the productive/prohibitive cycle of feminized dissatisfaction and discipline. Notwithstanding the complex reasons why individuals are drawn into anorexic practices or the particular individual meanings these practices hold, pro-anas do not say they want to be *female* (or desirable, or feminine)—they just want to be *thin*. In this moment, pro-anorexic discourse paradoxically situates the thin aesthetic as both as sign and signifier, exposing it as an elusive ideal. In taking up the thin aesthetic to the exclusion of all else, pro-anas almost displace femininity entirely: it is emptied of its intended content, and its thin aesthetic is no longer palatable. Of course, the thin aesthetic is inextricably tied to feminized subjectivation; it is not simply about thinness. But, it is pro-anas who are penalized for calling out the subversive potential located in this discursive slip.

In fact, Karen Dias argues that pro-anorexia reflects the contradictory experiences of female embodiment in which "we can detect discourses of resistance"[134]:

> we can also see individual agency in these women's attempts to reach out to one another and create safe, nonjudgmental spaces. Though pro-ana sites do appear to visually reinforce hegemonic norms by showing mainstream images of acceptable female beauty alongside images of deviant bodies, their very presence in public spaces and their ability to resist and subvert pressures to behave creates something of a parody of these impossible norms and demonstrates their agency . . . in spite of the backlash. The judgmental responses of practitioners in the field of eating disorders separate the girls and women who do not want help from those who are ready to seek help. These simply reinforce dominant binaries of good/compliant girl and bad/resistant girl that have historically been used to pathologize and silence women.[135]

Pro-anorexia falls on the "bad" side of this binary for unsettling the boundaries of normative femininity. Disgust gives way to desire, recklessness reveals adherence, attempts to control the unruly body are again dismissed as irrational. Pro-anas are engaged with the same disciplinary apparatus as are other women, but its punitive force is imposed on them more overtly. Despite their adherence to the technologies of femininity, pro-anas have crossed a nebulous line demarking the acceptable practices of feminine discipline. In light of this, BlueDragonfly's imagined future of "wanting to be normal" is then a problematic undertaking: "normal" without the angst of feminized bodily dissatisfaction may be hard to find.

"Allow me to introduce myself . . . . you may call me Ana"[136]

In the pro-anorexic search for an end to the angst of feminized bodily dissatisfaction, the identity of "ana" takes over. While often advocating for their shared identity with a defiant public voice, the identities of pro-anas themselves disappear beneath the broader identity which they seek. Hidden further through the internet anonymity of pseudonyms and webnames, these women pursue the identity of "ana" while effacing their own. And, though many pro-anas find support in their cyber-exchange, this disappearance mirrors the contradictory constraints embedded in their own subjectifying struggles with feminized discipline. In taking normative femininity to its extreme, pro-anas literalize its conflicting demands so that we may read them—not only on the bodies of these individuals, but also on the pages of their websites. Contemporary heteronormative womanhood is constituted precisely through the disciplinary regimes of diet, dress and exercise, as well as through the angst upon which these regimes rely; but, pro-anorexic discourse reveals this disciplinary subjectivation as unstable. Its multiplicitous texts call out the impossibilities of feminized disciplines: women are subjectified through their disciplinary practices, but can never achieve their disciplinary goals. Feminized identity is always a fraught undertaking. Participants in the pro-anorexia movement thus become "ana" to rid themselves of the subjectified bodies which prompt their inadequacy and to produce, in turn, the contradictory possibility of identity within these harsh disciplinary constraints.

At its most obvious and superficial, pro-anorexic discourse reiterates women's hegemonic subjectivation via the thin feminine aesthetic. Where their bodies fail to measure up, pro-anas instead endlessly reproduce iconic representations of women on their webpages. Borrowing liberally from mainstream culture, the images to which pro-anas aspire are those of the dominant discourse, variations of which are marked as either exotic or deviant within a discourse marked as deviant itself. Western icons of white, thin, young femininity rarely give way to images of women of other "colours," backgrounds or ethnicities. "Ability" and heterosexuality are hegemonically implied by the absence of anything else. While such representations may or may not reflect the individual identities of pro-anas, they do reveal the extent to which pro-anorexic discourse is entwined with hegemonic subjectivations of female identity—the limited permutations of the young, thin, pretty, white icon of hetero-desire.

Pro-anorexic images which veer from this iconic femininity illustrate the pain of ana/mia struggles, as well as demonstrating the insight that pro-anas have into their troubled subjectivation—artwork depicting waifish illness (see Figure 7), portraits which crop out identity (see Figure 8), bodies layered with the identity of others (see Figure 9), images of their blunt reality (see Figure 10).

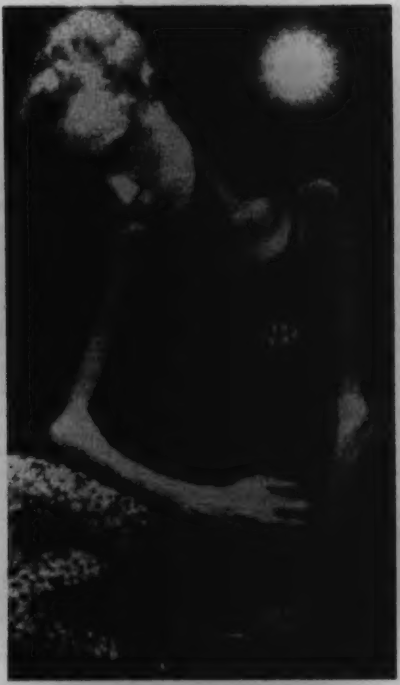

Figure 7. Image of "Neon Ana," captioned as "Toxic Ana: The Secret Virus."[137]

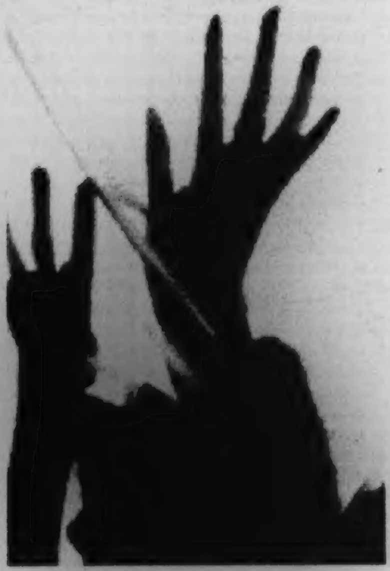

Figure 8. Photograph entitled "Let me be."[138]

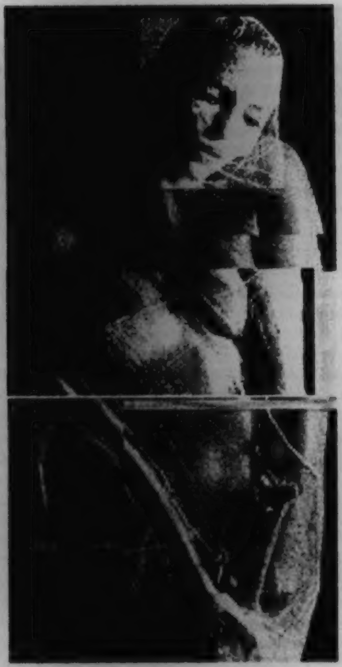

Figure 9. Body collage entitled “Dollparts.”[139]

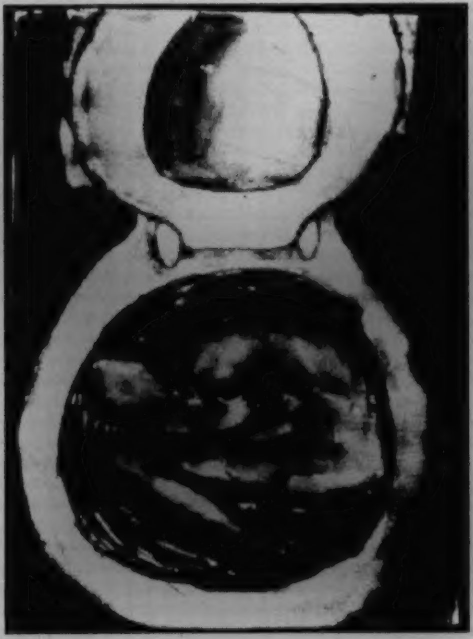

Figure 10. Ana/mia artwork entitled “Bulimia: An Artist’s Conception.”[140]

Such images reiterate the struggles of pro-anas, but also mark their absence, their pathologization, their fragmentation—their punitive subjectivation—through the multiple discursive regimes with which they are entangled. In medical logic, pro-anas become diagnostic criteria—the virus of ana—morphing into the quantifications of body mass index, electrolyte levels and degrees of weight loss. With subsequent pathologization, these individuals are excluded from the realm of "normal," their subjectification as "women" thereby denied. Mainstream culture fails to recognize their anorexic bodies within this subjectivation, but simultaneously sees only the anorexic body—objectified, pathologized, divided into parts for observation. The identities through which this body is produced are muted by punitive disciplinary force and social outcry. Thus discursively absented from their own subjectivation, pro-anas extend this disciplinary prompt of abjection, just as they extend the terms of disciplinary femininity. Paradoxically, participants in this movement erase their identities and attempt to eviscerate the contents of their unbearably female bodies in order to take on the terms of these subjectivating regimes.

Moreover, pro-anorexic discourse replaces the painfully fraught subjectivities of its participants with the overriding identity of "Ana." "Ana" is personified, enabling "her" resignification beyond medical control and social stigma. She personifies at once anorexia—abstracted from the individual—and the anorexic struggles distinctly embodied in the individual. Either way, "Ana" supersedes the individual identity, simultaneously calling out and silencing the overwhelming constraints of normative femininity. A "Letter from Ana," reproduced on numerous pro-anorexic websites and which I cite at length here, exemplifies this contradictory identification:

> Allow me to introduce myself. My name, or as I am called by so called "doctors," is Anorexia. Anorexia Nervosa is my full name, but you may call me Ana . . . . I am beginning to imbed myself in you. Pretty soon, I am with you always. I am there when you wake up in the morning and run to the scale . . . . I am there when you figure out the plan for the day: 400 calories, 2 hours exercise. I am the one figuring this out, because by now my thoughts and your thoughts are blurred together as one . . . . The hunger pains you pretend not to feel [are] me, inside of you. Pretty soon I am telling you not only what to do with food, but what to do ALL of the time . . . . I'll force you into the bathroom, onto your knees, staring into the void of the toilet bowl. Your fingers will be inserted into your throat, and, not without a great deal of pain, your food binge will come up . . . . Or perhaps I just make you hurt yourself, bang your head into the wall until you receive a throbbing headache. Cutting is also effective. I want to see your blood, to see it fall down your arm, and in that split second you realize you deserve whatever pain you get . . . . Oh, is this harsh? Do you not want this to happen to you? Am I unfair? I do do things that will help you. I make it possible for you to stop thinking of emotions that cause you stress. Thoughts of anger, sadness, desperation, and loneliness can cease because I take them away and fill your head with the methodic calorie counting . . . . I am your only friend, and I am the only one you need to

> please. I have a weak spot. But we must not tell anyone. If you decide to fight back, to reach out to someone and tell them about how I make you live, all hell will break [loose]. No one must find out, no one can crack this shell that I have covered you with. I have created you, this thin, perfect, achieving child. You are mine and mine alone. Without me, you are nothing.[141]

Reflecting the facetious pro-anorexic "religion,"[142] "Ana" is its charismatic leader, offering up a mantra of diet ads flimsily superimposed on Judeo-Christian beliefs in order to produce appropriately docile bodies. Her religious rituals are those of daily weigh-ins and calorie counting; catechism comes in the form of "tips and tricks," questions asked—and answered—on message boards. Cult-like, she wills her followers to do as she commands, evacuating their bodies of their appalling contents, filling the empty shells with the promise of perfection, replacing their inadequate identities with her own.

Marked by shame and illicit fascination, her followers are rejected by mainstream culture. Thus, the internet serves "Ana" well, its pseudonymous exchange facilitating the isolation and concealment required by her participants. With the gaze already well entrenched in feminized disciplines, pro-anorexic discourse employs it anew to extend its practice into the "nowhere-somewhere" impossible space of the internet.[143] One can imagine a young woman at her computer, alone, hands occupied to avoid eating. She types, her eyes read, and the gaze emerges (again) as a disciplinary mediator, producing thinspiration and drinking it in. Indoctrinated already with the mainstream messages of discipline and disgust, the gaze now enables the possibility of both escape from rejection and from the body itself. Through its productive vision, the body may be absented, or at least distanced, via modem and ethernet link, the gaze superseding its limited encasement.

The utopian discourse of cyberpunk champions virtual space as a realm through which the "meat" of the body may be abandoned,[144] computer technology carving off "the dead flesh that surrounds the active mind which constitutes the 'authentic' self"[145]—the "true self" of ana (or mia, or "rexie") emerging from beneath it. Once this disembodiment is achieved, cyberspace enables the ironic potential of a newly idealized body. Deborah Lupton writes: "the idealized virtual body does not eat, drink, urinate or defecate; it does not get tired; it does not become ill; it does not die"[146]—a body, then, disembodied of its physical needs and failings, a body well suited to pro-anorexia. The postmodern vision of the cyborg takes this idealism further, promising to eradicate the constraining binaries of modern life and to blur the boundaries that limit human flesh,[147] again suggestive of pro-anorexic potential.

While Debra Ferreday rightly asserts that "'pro-ana' websites that celebrate eating disorders aim to create a community in which a sense of collectivity is constituted precisely through the body, specifically the anorexic body,"[148] I would suggest that the appeal of the internet to pro-anorexia is precisely its ability to transcend or, at least, absent the body—even if temporarily. Although pro-anorexic discourse revolves precisely around the body, or the multiple unacceptable bodies of its participants, this potential elision of embodiment within virtual space is strikingly appropriate for its purposes: individuals struggling to throw off the burden of bodies that are not perfect do so in a strangely disembodied forum. The "nowhere-somewhere" of cyberspace enables a doubled disappearance—at once from the complexly unintelligible bodies of pro-anas themselves and from the embodied space through which they are subjectified as such. This disappearance is doubled again as the already pseudonymous identities of pro-anas are effaced by the overriding identity of "Ana." With this at least momentary diffusion of their fraught subjectivities, pro-anorexic discourse then rewrites the thin ideal —with each tip or trick shared, each image posted—outside the always imperfect space of the body, reiteration redoubling its impetus.

Yet, this doubled disappearance—and its redoubling of the thin aesthetic—perpetually trips in on itself, the now disembodied gaze of the individual bringing her back to her room, her computer, her imperfect body. As Anne Balsamo argues, "the body can never be constructed as a purely discursive entity. In a related sense, it can never be reduced to a pure materialist object . . . . This is to assert that the material and the discursive are mutually determining and non-exclusive."[149] With each keystroke and each click of the mouse, the virtual elision of the anorexic body is thus painfully, and perpetually, returned to the materially discursive space of normative femininity. Within this reality, the doubly absented body of the pro-ana fits too well within the cultural desire to silence and diminish the female body. While the female body is itself discursively constituted as always inadequate, the specific pro-anorexic body is further subjectified as more pathological, more disgusting, more unintelligible. And, in turn, this body is erased by the exact practices which it avows. The pro-anorexic resignification of the thin ideal is, then, overwritten by the perpetual disciplinary failures of the individual, the hyperlink to embodied practices again demonstrating their reality. While pro-anas efface the subjectified bodies which constrain them, they cannot escape the painful link back to their bodies through diet and discipline.

Thus, while cyberspace is often conceived as the domain through which identities become composable/polymorphous/unconstrained,[150] it is the singular identity of "Ana" that pro-anas reiterate and the constraining feminine ideal which they compose. Although cyberspace is envisioned by some as the new realm of collectivity and public democracy,[151] pro-anas are repeatedly evicted from this pseudo-space for their distasteful discourse, pushing them further into virtual exile. And, while pro-anorexia may confound our boundaries between machine/organism, disgust/desire, mind/body, rebellion/conformity, it does not emerge in a post-gender cyborg world as Donna Haraway would suggest.[152] Instead, it employs cyber-technology as a means to eviscerate the tortured contents of the unsavoury, leaky, messy female body. Cyberspace cannot ensure the pro-anorexic escape from the multiply constrained embodiment of feminized discipline.

What is possible in cyberspace, however, is the speaking—or, more appropriately, writing and reading—of such things. A voice is enabled, where an unencumbered identity is not, through which to speak in embodied and written text of the constraints of contemporary femininity. Its virtual textualization on pro-anorexic webpages invokes an impossible space—both the virtual "nowhere-somewhere" and the impossible realm of pro-anorexic speech—in which this embodied uneasiness becomes acceptable. Anorexic discourse is already firmly entrenched in our culture, but without a voice. Its repression produces the opposite effect, pushing it into virtual space. In turn, the censoring of pro-anas prompts a renewed commitment to their cause, yet disembodies their vocal rebellion. In their struggle to resolve the constant elisions produced by their feminized discipline, they come to lie deeper in the virtual body, beneath the skin of the all-consuming "Ana."

Notes

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[1] This particular version of the "Ana Creed" is taken from: Alleee and Franc's Insolitology, "The Ana Creed," http://www.insolitology.com/health/anorexia.htm (accessed February 29, 2004).

[2] Many pro-anorexia websites cited in this chapter have now been suspended and/or re-established under different URLs. Due to the continual changes with pro-anorexia websites, I cite these websites by date accessed in all cases, and have retained print outs of all cited websites. As well, little consistency exists in the publication data for pro-anorexia websites; where either title or webname are not clear, I cite by the URL, as per standard citation practices. Finally, as informal texts, many pro-anorexia websites include spelling and grammatical errors; when quoting such material, I leave the text as it was originally written, unless the errors substantively disrupt readability.

[3] Brumberg, *Fasting Girls*, xvii.

[4] See De Fabrizio, "Symbolic Disorder."

[5] Brumberg, *Fasting Girls,* xvii (emphasis in original).

[6] Foucault, *History of Sexuality*, esp. 10-12 and part 2.

[7] See, for example: Bordo, *Unbearable Weight*; and, Brumberg, *Fasting Girls*.

[8] Friedan, *Feminine Mystique*, esp. chap. 1.

[9] "Pro-anorexia" clearly emerged into pop culture discourse at the turn of the twenty-first century, as it attracted the attention of mainstream media. BBC News reported on anorexia websites in May, 2001 (see Franklin, "Anorexia Websites"), with *Time* and other news outlets picking up the story in the summer of 2001 (see,

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for example, Holahan, "Yahoo Removes"; and Reaves, "Anorexia Goes High Tech"). However, a 1997 *Redbook* article reported that Dr. Ira Sacker was warning of a developing trend he called "cyberexia," the use of online support groups for recovering anorexics and bulimics as a source for weight loss ideas. This reference may locate pro-anorexia, or Sacker's cyberexia, as beginning in the mid- to late 1990s. See Newman, "Little Girls Who Won't Eat." Newman's *Redbook* article is also cited on the website "Eating Disorder Resources" as the earliest media reference to pro-anorexia; see Eating Disorder Resources, "edr: pro-???: media coverage," http://www.eatingdisorderresources.com/proarticlesbydate.htm (accessed May 9, 2005).

[10] I use the term "pro-ana" throughout this chapter to refer to the shared pro-anorexic identity and movement, distinguishing it by its alternative names where needed.

[11] See, for example, Blood Red Bracelet, http://www3.sympatico.ca/slendergoth (accessed May 10, 2005); and, Gothic Rose, "You Stole the Stars," http://www.anglefire.com/pro/tears (accessed May 11, 2005);

[12] See, for example, the "Pro-Ana-Suicide Society," http://pub82.ezboard.com/bproanasuicidesociety (accessed November 29, 2004).

[13] Most online pro-anorexia forums have discussions dedicated to "SI" or self-injury, as do some pro-anorexia websites. For example, see the webmistress's link at "Cerulean Butterfly" to her "SI" page: Razorblade Rose, "Razorblade Rose," http://www.rrose.ceruleanbutterfly.com/ (accessed May 26, 2005).

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[14] Future Perfect, "Future Perfect: A Site About Anorexia and Bulimia," http://hiddenmia.diaryland.com/ (accessed May 9, 2005).

[15] Am I Invisible Yet?, "Am I Invisible Yet? Scow Rambles Again," http://cannibalz.diaryland.com/021202_40.html (accessed February 29, 2004).

[16] Nothings Gonna Stop Me From Floating, "Nothings Gonna Stop Me From Floating," http://www11.brinkster.com/starvation/inside.html (accessed May 18, 2005).

[17] Please note that the pro-anorexia images included in this chapter are taken from websites and/or parts of websites that are in the public domain. With each of the pro-anorexia images included, the author, artist or composer of the image was not listed on the websites. Therefore, I cite these images by the title listed on the particular website (if a title was listed) and by the specific URL. For an exception to this public domain use, please see the *Adbusters* "Obsession" image (Figure 2) that was used in accordance with *Adbusters*' permissions policies; see note 51, below, for further details.

[18] Wasted Shadow, "The Pro-Ana Ribbon," http://www.wasted.fabpage/ (accessed May 9, 2005).

[19] Udovitch, "A Secret Society of the Starving," 20.

[20] Ana's Underground Grotto, "Background/Philosophy," http://www.plagueangle.net/grotto/id1.html (accessed May 18, 2005) (emphasis mine).

[21] Udovitch, "A Secret Society of the Starving," 20-21.

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[22] For discussion of the relationship between anorexia and control see, for example, Bordo, *Unbearable Weight*; Gremillion, *Feeding Anorexia*; and, Malson, *The Thin Woman*.

[23] Ana's Underground Grotto, "Background/Philosophy – Background," http://www.plagueangel.net/grotto/id1.html (accessed May 18, 2005).

[24] Ana's Underground Grotto, "Background/Philosophy – Background," http://www.plagueangle.net/grotto/id1.html (accessed May 18, 2005) (emphasis in original).

[25] Many sites include the "pro-ana" or "pro-ED" ribbon on their homepages, as well as identifying pro-anorexia or pro-ED as a lifestyle in the text of their sites, but offer little discussion beyond these references. See, for example, The House of ED, "Welcome to the House of ED," http://www.freewebs.com/ananeverdies/ (accessed April 28, 2005). Other sites offer more extensive discussion of the "ana" identity, but in a similarly vague fashion. At "Victoria's Pro-Ana Journal," for instance, the webmistress distinguishes between "ana" and "anorexia" in relation to "bone images." She acknowledges that some individuals find bone images "useful," but notes that she finds them "disgusting," thereby implying a line between what is acceptable for "pro-ana" and what is not. See Victoria's Pro-Ana Journal, "Bone Thinsperation," http://www.victoriasproana.com/5bone.html (accessed May 10, 2005).

[26] Ana's Underground Grotto, "Background/Philosophy – Background," http://www.plagueangel.net/grotto/id1.html (accessed May 18, 2005) (emphases in original).

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[27] BlueDragonfly, "The Mission Statement," http://bluedragonfly.org/ (accessed May 17, 2005) (emphases in original).

[28] Cerulean Butterfly, "To those of you who come here looking to 'become anorexic,' or to yell at us…," http://www.ceruleanbutterfly.com/disclaimer.html (accessed May 18, 2005).

[29] Alleee and Franc's Insolitology, "Ana's Creed," http://www.insolitology.com/health/anorexia.htm (accessed February 29, 2004).

[30] Anorexic Nation, "Ana's Religion – The Thin Commandments," http://www.futurebird.com/~dietpep/anorexicnation/anareligion.html (accessed November 28, 2002).

[31] AnOreXic AdDiCt, "Anorexic Psalm," http://myweb.ecomplanet.com/BOUC2329/mycustompage0006.htm (accessed November 11, 2002).

[32] These techniques are distributed throughout the "Anorexic Nation" website; see Anorexic Nation, "Anorexic Nation – A Pro Ana Mia Website," http://www.futurebird.dom/~dietpep/anorexicnation/right.html (accessed November 28, 2002).

[33] The House of ED, "The Bathroom: Life's a Struggle, So Fight It – Tips," http://www.freewebs.com/ananeverdives2/tips.htm (accessed May 28, 2005).

[34] AnOreXiC AdDiCt, "Safe Foods," http://myweb.ecomplanet.com/BOU2329/mycustompage0016.htm (accessed November 28, 2002).

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[35] Chaotic Serenity, "Food," http://www.freewebs.com/iris7/food.htm (accessed May 25, 2005).

[36] Living With Ana, "Disgusting Food," http://www.living-with-ana.com/gpage.html6.html (accessed May 26, 2005).

[37] See, for example, Anorexic Nation, "Pills," http://www.futurebird.com/~dietpep/anorexicnation/thepills.html (accessed November 28, 2005); and, Cerulean Butterfly, "Diet Pills," http://www.ceruleanbutterfly.com/pills.html (accessed May 9, 2005).

[38] See, respectively, Cerulean Butterfly, "Foods – The 2-4-6-8 Plan," http://www.ceruleanbutterfly.com/2468.html (accessed May 9, 2005); Cerulean Butterfly, "Foods – The 3-Day Diet," http://www.ceruleanbutterfly.com/3day.html (accessed May 9, 2005); and, Cerulean Butterfly, "Foods – The Cabbage Soup Diet Plan," http://www.ceruleanbutterfly.com/cabbagesoup.html (accessed May 9, 2005).

[39] See Hornbacher, *Wasted.*

[40] A Walking Barbie, "What a Girl Eats - Diets," http://www.freewebs.com/anaprincessheather/whatagirleats.htm (accessed May 10, 2005).

[41] Anorexic Nation, "Fasting," http://www.futurebird.dom/~dietpep/anorexicnation/fasting.html (accessed November 28, 2002).

[42] Victoria's Pro-Ana Journal, "Fasting," http://www.victoriasproana.com/3fasting101.html (accessed May 10, 2005).

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[43] See, for example: Cerulean Butterfly, "Tools – BMI Calculator," http://www.ceruleanbutterfly.com/bmi.html (accessed May 9, 2005); Cerlean Butterfly, "Tools – BMR Calculator," http://www.ceruleanbutterfly.com/bmr.html (accessed May 9, 2005).

[44] See, for example, Chaotic Serenity – A Support System for Anyone with an ED, "Chaotic Serenity – A Support System for Anyone with an ED," http://www.freewebs.com/iris7/exercise.htm (accessed May 25, 2005); and, A Walking Barbie, "Body Like Barbie," http://www.freewebs.com/anaprincessheather/bodylikebarbie.htm (accessed May 10, 2005).

[45] Cerulean Butterfly, "Cerulean Butterfly – Exercises," http://www.ceruleanbutterfly.com/exercises.html (accessed May 9, 2005).

[46] See, for example, Future Perfect, "Thinspiration Quotes," http://hiddenmia.diaryland.com/quotes.html (accessed May 9, 2005);

[47] Ana's Underground Grotto, "Thinspiration Photos," http://www.plagueangel.net/grotto/id2.html (accessed May 9, 2005).

[48] Ana's Underground Grolto, "Reverse Triggers," http://www.plagueangel.net/grotto/id11/html (accessed May 24, 2005); see also the following site from which the image to which the "Grotto" refers was taken: Uglypeople, www.uglypeople.com.

[49] Ana's Underground Grotto, "Reverse Triggers," http://www.plagueangel.net/grotto/id11/html (accessed May 24, 2005).

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[50] Victoria's Pro-Ana Journal, "Bone Thinsperation," http://www.victoriasproana.com/5bone.html (May 10, 2005).

[51] Specifically, this image was included on the "Ana/Mia Artwork" thinspiration page at Ana's Underground Grotto; see Ana's Underground Grotto, "Ana/Mia Artwork," http:www.plagueangle.net/grotto/id14.html (accessed May 9, 2005). For the original image, see Adbusters, "Culture Shop – Postcards, Obsession for Women," www.adbusters.org/orders/postcards/ (accessed July 22, 2005). See also Appendix II: Reprint Permission from *Adbusters*.

[52] These images were located at: Victoria's Pro-Ana Journal, "Bone Thinsperation," http://www.victoriasproana.com/5bone.html (accessed May 24, 2005).

[53] These images were located at: Victoria's Pro-Ana Journal, "Bone Thinsperation," http://www.victoriasproana.com/5bone.html (accessed May 24, 2005).

[54] Wasted Shadow, "Celebrity Stats," http://www.wasted.fabpage.com/custom2.html (accessed May 9, 2005).

[55] Wasted Shadow, "Thinspiration," http://www.wasted.fabpage.com/photo.html (accessed May 9, 2005).

[56] For the homepage and the "Paris Hilton" diet/exercise regimes respectively, see A Walking Barbie, "The Journey to Perfectionism.....," http://www.freewebs.com/anaprincessheather/ (accessed May 10, 2005); and, A Walking Barbie, "Glamour Girls,"

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http://www.freewebs.com/anaprincessheather/glamourgirls.htm (accessed May 10, 2005).

[57] Respectively, see Ana's Heaven, "Alterted [Altered] Photos," http://angelana.bravehost.com/alteredthin.html (accessed May 24, 2005); and, Ana's Heaven, "Celebrity Eating Disorders," http://angelana.bravehost.com/edsofcelebs.html (accessed May 10, 2005).

[58] As my focus is the shared pro-anorexic discourse, I did not undertake an intensive analysis of the chatrooms, discussion boards, and other forums for personal exchange included on many pro-ana websites. My analysis addresses primarily the public domain material of this movement. I include general discussion of them here since such forums are a core element of many pro-ana websites. For more detailed analysis of pro-anorexic forums, see for example, Dias, "The Ana Sanctuary."

[59] Pro- Ana-Mia-Ed Society, "Pro- Ana-Mia-Ed Society," http://p217.ezboard.com/bproanamiaedsociety (accessed May 12, 2005).

[60] Behind Closed Doors, "Forum List," http://aplaceformymind.proboards3.com/ (accessed May 18, 2005).

[61] See, for example, Stop Pro-Ana, "Stop Pro-Ana," http://www.ethical-business.com/default.asp?sect=detail&pet=471 (accessed May 12, 2005); and, Stop Pro-Ana. Please., "Stop Pro-Ana. Please.," http://stop-pro-ana.com/ (accessed May 12, 2005). Similarly, a webpage with the banner "Pro Anorexia and Bulimia Web Sites" links to S.C.a.R.E.D. (Support Concern and Resources for Eating Disorders), an anti-pro-anorexia website; see Support Concern and

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Resources for Eating Disorders, "Support Concern and Resources for Eating Disorders," http://www.eating-disorder.org/prosites.html (accessed September 26, 2002).

[62] National Association of Anorexia Nervosa and Associated Disorders (ANAD), "Thank You for Your Honor and Integrity," http://www.anad.org/proanorexia.htm (accessed November 28, 2002).

[63] National Association of Anorexia Nervosa and Associated Disorders (ANAD), "Become an ANAD Media and Internet Guardian," http://www.anad.org/site/anadweb/section.php?id=3116&pos=0&print=1 (accessed May 26, 2005).

[64] Along with ANAD (see notes 56 and 57), see The National Eating Disorders Association, "NEDA Position Paper on Pro-Anorexia and Pro-Bulimia Websites," http://www.nationaleatingdisorders.org/p.asp?WebPage_ID=779 (accessed May 27, 2005); The National Eating Disorder Information Centre, "Welcome to the National Eating Disorder Information Centre," http://www.nedic.ca/default.html (accessed May 27, 2005); Something Fishy Website on Eating Disorders, "We are a PRO-Recovery Webiste," http://www.something-shifhy.org/sfwed/prorecovery.php (accessed May 27, 2005); and, Something Fishy Website on Eating Disorders, "WWW.Warning -- Negative Internet Sites," http://www.something-shifhy.org/isf/reading.php (accessed May 27, 2005).

[65] See Holahan, "Yahoo Removes"; and, Reaves, "Anorexia Goes High Tech."

[66] Along with various kinds of account suspension noticies, many URLs are rerouted by internet service providers. For example, upon selecting the hyperlink

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to either "AnorexicAnna.com" or "AnorexicBeauty.com," one is connected with a webpage listing treatment programs and support services. See AnorexicAnna.com, "Anorexic by Anna Paterson," http://anorexicanna.com (accessed May 25, 2005); and, AnorexicBeauty.com, "Sponsored links for ANOREXIA," http://www.anorexicbeauty.com (accessed May 17, 2005). Despite the fact that "AnorexicAnna.com" is a page produced by a former anorexic now dedicated to helping individuals overcome their eating disorders, the site in this particular form was blocked by its internet service provider. It is now available as Anna Paterson, "Anna Paterson," http://www.anorectic.fsnet.co.uk/ (accessed May 25, 2005).

[67] The Skinny: A Webzine for Anorexia and Bulimia, "The Skinny: A Webzine for Anorexia and Bulimia," http://www.angelfire.com/ca/TheSkinny (accessed May 26, 2005). See also Phetermine.com: the Official Site, "About Phentermine.com," http://www.phentermine.com/ (accessed May 26, 2005).

[68] These three advertising slogans were located in a header banner on one of the internal pages of "The House of ED"; see The House of ED, "The Bathroom: Life's a Struggle, so Fight It – Quotes," http://www.freewebs.com/ananeverdies2/quotes.htm (accessed April 28, 2005).

[69] For example, "Ana's Underground Grotto" provides links to a number of religious fasting websites, including: Freedomyou, "Freedomyou: For All You are Meant to Be – Fasting Center," http://www.freedomyou.com/level%202/Fasting%20Page%20Guide.htm (accessed May 26, 2005). Similarly, the pro-anorexia site "Salvation Through

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Starvation" links to "Fitday.com." See, respectively, Salvation Through Starvation, "Links," http://www.dazzled.com/caitlinana/links.html (accessed May 26, 2005); and, Fitday.com, "Fitday.com – Your online diet and fitness journal!," http://www.fitday.com/ (accessed May 26, 2005).

[70] See, for example, I Love You To The Bones, "I Love You To the Bones," http://ringsurf.com/netring?action=info&ring=tothebones (accessed May 10, 2005).

[71] Although a number of online pro-pro-ana campaigns exist and the pro-pro-ana ribbon is used extensively on pro-anorexia websites, one of the first sites to launch a "pro-pro-ana" campaign was the now defunct "Anorexic Nation." See Anorexic Nation, "Welcome to Anorexic Nation – A Pro Ana Mia Website," http://futurebird.com/~dietpep/anorexicnation/right.html (accessed November 28, 2002).

[72] See, for example, Udovitch "A Secret Society of the Starving"; and, *Oprah Winfrey Show*,"Girls Who Don't Eat," October 4, 2001.

[73] While some sites offer bracelets which symbolize ana/mia practices differently, these particular codings are fairly common. For example, see BlueDragonfly, "Frequently Asked Questions About Bracelets," http://www.bluedragonfly.org/braceletfaq.html (accessed October 18, 2004).

[74] These examples are taken from the now defunct link to the Cerulean Butterfly webstore; see Cerulean Butterfly Store, http://www.cafepress.com/ejchristian86 (accessed May 5, 2005). As of July 19, 2005, a newly launched Cerulean

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Butterfly site is selling bracelets. See Cerulean Butterfly, "Bracelets, http://ceruleanbutterfly.com/bracelets/side.html (accessed July 19, 2005).

[75] Wasted Shadow, "Wasted, empty and lonely," http://www.wasted.fabpage.com (accessed May 18, 2005).

[76] This statement was listed under the "Clikc to Chat!" entry of the navigation menu for "Beautiful Perfection"; see Beautiful Perfection – Longing to be Beautiful, "Beautiful Perfection – Longing to be Beautiful," http://freewebs.com/pure_perfection/ (accessed May 26, 2005).

[77] When you select a link to or enter the URL for "Cerulean Butterfly," these three messages pop up. You cannot enter the site without selecting the "OK" box on each warning. See Cerulean Butterfly, "Cerulean Butterfly," http://www.ceruleanbutterfly.com/ (accessed May 12, 2005). This particular link is now defunct; see also Cerulean Butterfly, "Cerulean Butterfly," http://ceruleanbutterfly.com/ (accessed July 21, 2005).

[78] Makayla's Healing Place, "We All Need Understanding" Banner, http://www.makaylashealingplace.dnswh.com/ (accessed May 23, 2005).

[79] This "Anorexia –Cannibalism Sticker" is sold by "Anorexic Web" at Cafepress.com. See Cafepress.com, "Cafepress.com – Anorexic Web," http://www.cafepress.com/anorexicweb (accessed July 21, 2005.)

[80] McCourt, *'Tis: A Memoir*, 260. This passage is quoted (with a few errors in accuracy) as a website banner at: BlueDragonfly, "The Mission Statement," http://www.bluedragonfly.org/ (accessed October 18, 2004). While McCourt's words serve the rhetoric of pro-anorexia well, in his book this statement is spoken

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by a disturbed drifter who, having wandered into the protagonist's life, seeks spiritual enlightenment by forsaking the trappings of the material world.

[81] "@ the Doctor's Office" is one of the informational categories available at Cerulean Butterfly; see Cerulean Butterfly, "At the Doctor's Office," http://www.ceruleanbutterfly.com/doctor.html (accessed June 5, 2005).

[82] For full discussion of the development of this process, see Foucault, *Birth of the Clinic*, chap. 2 and chap. 6.

[83] Abraham and Llewellyn-Jones, *Eating Disorders*, 26. The authors have modified these criteria from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (4th edition; 1994).

[84] Foucault, *Birth of the Clinic*, 34 (emphases in original).

[85] Ibid., 35 (emphasis in original).

[86] The medical epistemological extension of Cartesian dualism has been illustrated by numerous feminist theorists and researchers. In a large body of literature, see for example, Bell, "Reluctantly Finding Woman as Death"; Bordo, *Unbearable Weight*; Jordanova, "Natural Facts"; Lupton, *Medicine as Culture*; Shildrick, *Leaky Bodies*; Walker, *Philosophy and the Maternal Body*; and, Young, "Pregnant Embodiment." For further discussion, see also Chapter 1, "The Postmodern Cultural Clinic."

[87] See, for example, Chernin, *The Hungry Self*; Chernin, *The Obsession*; Eckermann, "Foucault, Embodiment and Gendered Subjectivities"; Gremillion, *Feeding Anorexia*; Hepworth, *The Social Construction of Anorexia Nervosa*;

Lester, "The (Dis)Embodied Self in Anorexia Nervosa"; and, MacSween, *Anorexic Bodies*.

[88] Bordo, "Anorexia Nervosa," 139-140.

[89] Malson, *The Thin Woman*, 33 (emphasis in original).

[90] Nasser, *Culture and Weight Consciousness*, 95-97, 104-107

[91] Thompson, *A Hunger So Wide and So Deep*.

[92] For example, see Andersen, Bowers, and Evans, "Inpatient Treatment"; Anderson, "Analysis of Treatment Experience"; Fairburn, Marcus, and Wilson, "Cognitive Behavioural Therapy"; Draper, "Treating Anorexics"; Goldner, "Treatment Refusal"; Mitchell, Parker, and Dwyer, "The Law and a Physically-ill Patient"; Tiller, Schmidt, and Treasure, "Compulsory Treatment"; and, Vandereycken and Beumont, *Treating Eating Disorders*.

[93] See, for example, Bell, "Re/forming the Anorexic 'Prisoner'"; Gremillion, *Feeding Anorexia*; Gremillion, "In Fitness and in Health"; Gremillion, "Psychiatry as Social Ordering"; Malson, *The Thin Woman*; and, Sesan, "Feminist Inpatient Treatment." See also Chapter 4, "Re/forming the Anorexic 'Prisoner'."

[94] Sesan, "Feminist Inpatient Treatment," 251.

[95] Gremillion, *Feeding Anorexia*, 32.

[96] Traditional medical approaches to disordered eating assume that a necessary self-discipline is lacking in the anorexic patient and, consequently, treat this patient as a medicalized object ostensibly unaware of his/her condition. However, many women struggling with disordered eating are intensely aware of their practices and, in fact, actively manipulate the terms of their treatment protocols.

Helen Gremillion notes, for instance, the adept skill of anorexic inpatients at maintaining or manipulating their prescribed "goal weight," deliberately reinterpreting it as an acceptable maximum weight rather than an acceptable minimum weight. See Gremillion, *Feeding Anorexia*, 47.

[97] Ruth Bankey, "La Donna e Mobile: Constructing the Irrational Woman," *Gender, Place and Culture* 8, no. 1 (2001): 27-54, as cited in Dias, "The Ana Sanctuary," 32.

[98] For example, "Anorexic Nation" lists and discusses the multiple physical, behavioural, and psychological characteristics of anorexia nervosa and bulimia nervosa. See Anorexic Nation, "Anorexia Nervosa," http://www.futurebird.com/~dietpep/anorexicnation/anainfo.html (accessed November 28, 2002); and, Anorexic Nation, "Bulimia Nervosa," http://www.futurebird.com/~dietpep/anorexicnation/miainfo.html (accessed November 28, 2002). Similarly, "Cerulean Butterfly" details eating disorder information on anorexia, bulimia, compulsive over-exercising, binge-eating disorder, and eating disorders not otherwise specified (ED-NOS). See Cerulean Butterfly, "ED Info," http://www.ceruleanbutterfly.com/ (accessed May 9, 2005).

[99] House of Ana, "The Bathroom: Medicine Cabinet," http://www.freewebs.com/houseofana/thebathroom.htm (accessed May 25, 2005).

[100] Victoria's Pro-Ana Journal, "Fasting," http://www.victoriasproana.com/3fasting101.html (accessed May 10, 2005).

[101] House of Ana, "The Bathroom: Medicine Cabinet," http://www.freewebs.com/houseofana/thebathroom.htm (accessed May 25, 2005).

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[102] Cerulean Butterfly, "At the Doctor's Office," http://www.ceruleanbutterfly.com/doctor.html (accessed June 5, 2005) (emphasis in original).

[103] For examples and discussion of the practice of overloading see Chapter 4, "Re/forming the Anorexic 'Prisoner'," 18.

[104] Cerulean Butterfly offers tips on hiding disordered eating in the social world, under the table of contents heading "Hiding Our Friends"; see Cerulean Butterfly, "Hiding Your Eating Disorder: How to Keep the World from Finding Out," http://www.ceruleanbutterfly.com/hiding.html (accessed May 9, 2005).

[105] The House of ED, "The Bathroom: Excuses/Ways to Hide ED – At Home/School," http://www.freewebs.com/ananeverdies2/exuseshidinged.htm (accessed April 28, 2005).

[106] The House of ED, "The Bathroom: Excuses/Ways to Hide ED – At Home/School," http://www.freewebs.com/ananeverdies2/exuseshidinged.htm (accessed April 28, 2005).

[107] Debra Ferreday explores the abjection of the anorexic body through mainstream commentaries on the pro-anorexia movement which illustrate a strong affective response of disgust. See Ferreday, "Unspeakable Bodies," 288.

[108] The findings on the rate of premature death attributable to anorexia nervosa are highly variable, suggesting broadly that somewhere between 5 and 20% of individuals with anorexia nervosa will die as a result of the disease (Neumarker, "Mortality"). While research varies in terms of methodologies and measures, making direct comparisons difficult, current findings indicate that the mortality

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rate for anorexia nervosa may be as low as 4.4% of patients (as a crude mortality rate) (Millar et al., "Anorexia Nervosa Mortality") and as high as 19% (Theander, quoted in Andersen et al., "Inpatient Treatment," 328). Analyses by Neumarker ("Mortality"), Sullivan ("Mortality"), and Eckert et al. ("Ten-year Follow-up") suggest a death rate of approximately 6%, while Deter and Herzog ("Anorexia Nervosa") found an 11% mortality rate; and, several other studies have found mortality attributable to anorexia to be between 15-16% (see, for example, Crisp et al., "Long-term Mortality"; Lowe et al., "Long-term Outcome"; Ratnasuriya, et al., "Anorexia Nervosa"; and, Zipfel et al., "Long-term Prognosis"). While some findings suggest substantively higher than expected death rates (Norring and Sohlberg, "Outcome"), others suggest lower than expected rates (Hewitt, Coren, and Steel, "Death"). The risk of death attributable to anorexia nervosa does appear to complicated by comorbidity with other conditions (see Keel et al., "Predictors"; and, Nielsen, Emborg, and Molbak, "Mortality"); and, suicide is identified as a major cause of death with anorexia nervosa (see Coren and Hewitt, "Is Anorexia Nervosa"; and, Nielsen et al., "Standardized Mortality"). Unfortunately, the prognosis for anorexia nervosa has not improved over the last century (Steinhausen, "Outcome").

[109] AnOreXic AdDiCt, "AnOreXic AdDiCt," wysiwyg://Main.109/http://myweb.ecomplanet.com/BOUC2329/home.htm (accessed November 28, 2002).

[110] BlueDragonfly, "The Mission Statement," http://www.bluedragonfly.org (accessed May 17, 2005).

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[111] In a large body of literature, see for example, Brown et al., "Relationship between Body Mass Index"; Colditz et al., "Weight Gain as a Risk Factor"; Consumer Reports on Health, "Moderate Exercise"; Enger and Bernstein, "Exercise Activity"; Evans, "Exercise Prescription"; French, "Stable Weight"; Glass, "Exercise for Women"; Hu, "Overweight and Obesity"; Hu et al., "Adiposity as Compared with Physical Activity"; Hu et al., "Television Watching"; Mack et al., "Health and Sociodemographic Factors"; Pirisi, "Obesity in Women"; and, Weinstein et al., "Relationship of Physical Activity."

[112] Polivy and Herman, "Diagnosis and Treatment of Normal Eating."

[113] McLaren and Kuh, "Body Dissatisfaction."

[114] See, for example, Kjærbye-Thygesen et al., "Why do Slim Women"; and, Thomas, "Body-Image Satisfaction."

[115] Abraham and Llewellyn-Jones, *Eating Disorders*, 21. Specifically, out of one hundred women interviewed in the immediate postpartum period: 71 watched their weight during pregnancy, 52 were preoccupied with thoughts of food; 41 believed they had difficulty controlling their weight gain during pregnancy; and, 20 indicated that their eating and weight problems were more severe during pregnancy than at any other time. Some women interviewed also used additional methods of weight control during pregnancy, including: excessive exercise (11%); smoking cigarettes (4%); periodic starvation (3%); laxative abuse (2%); and, self-induced vomiting (1%). These findings are also reported in: Abraham, King, and Llewellyn-Jones, "Attitudes to Body Weight".

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[116] See, for example, Thomas, “Body-Image Satisfaction”; and, Wardle and Foley, “Body Image.”

[117] Foucault, *Discipline*, 138.

[118] Ibid.

[119] Chernin, *The Obsession*.

[120] Haber, “Foucault Pumped.”

[121] Bordo, “The Body and the Reproduction of Femininity,” 166.

[122] Bartky, “Modernization of Patriarchal Power,” 81.

[123] *Woman's World*, Cover Page.

[124] *First for Women*, Cover Page.

[125] *Us Weekly*, Cover Page.

[126] *O: The Oprah Magazine*, Cover Page.

[127] *Chatelaine*, cover page and 11.

[128] Gormley, “Flatten Your Belly in Ten Minutes”; and, Mourtada, “Body Talk.”

[129] Respectively, see Weaver, “Instant Confidence!”; Schiedel, “My Body is Beautiful Because”; and, Paquet, “Girlpower!”

[130] *Glow*, Cover Page; and, Eull and Rae, “Beauty of Strength.”

[131] *Glow*, Cover Page.

[132] Bordo, “Reproduction of Femininity,” 169.

[133] Bordo, “Reproduction of Femininity.”

[134] Dias, “The Ana Sanctuary,” 41.

[135] Dias, “The Ana Sanctuary,” 41-42.

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[136] AnOreXic AdDiCt, "Letter From Ana," http://myweb.ecomplanet.com/BOUC2329/mycustompage0005.htm (accessed November 28, 2002).

[137] Ana's Underground Grotto, "Ana/Mia Artwork – Neonana," http://www.plagueangel.net/grotto/id14.html (accessed May 24, 2005).

[138] Ana's Underground Grotto, "Ana/Mia Artwork – Let Me Be," http://www.plagueangel.net/grotto/id14.html (accessed May 24, 2005).

[139] Ana's Underground Grotto, "Ana/Mia Artwork - Dollparts," http://www.plagueangel.net/grotto/id14.html (accessed May 24, 2005).

[140] Ana's Underground Grotto, "Ana/Mia Artwork - Neonana," http://www.plagueangel.net/grotto/id14.html (accessed May 24, 2005).

[141] The "Letter From Ana" is found on many pro-ana websites. I quote it at length here, but include only some of its lengthy ramblings. This particular version is from: AnOreXic AdDiCt, "Letter From Ana," http://myweb.ecomplanet.com/BOUC2329/mycustompage0005.htm (accessed November 28, 2002).

[142] While the "religious" content of the pro-anorexia movement may initially be read as a sign of its cohesiveness, its religious tone does not extend greatly beyond its shared pages/content. However, this religious framing may be referrent to the anorexics of old—the holy medieval saints who overcame their bodily needs to be closer to Christ. This refusal of food was considered a "female miracle" and "fasting was fundamental to the model of female holiness": it was predominantly medieval women forgoing food or dying of self-starvation in their

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commitment to Christ. "The medieval woman's capacity for survival without eating meant that she found other forms of food: prayer provided sustenance, as did the Christain eucharist" (Brumberg, *Fasting Girls*, 43-44). In the Middle Ages, survival without eating meant coming closer to God. With contemporary pro-anorexia, however, survival without food marks an enlightenment of a different sort—a freeing from a body marked as an encumbrance in and of itself, not an encumbrance to spirituality. And, as Brumberg notes, the social, cultural, and historical meaning of each "anorexia" is different (*Fasting Girls*, 5). These two socio-historical anorexias do not illustrate the same "disease." Instead, they demonstrate a similar outcome wrought from different cultural contexts or "routes of recruitment" (Brumberg, *Fasting Girls*, 40 and 44). At most, then, a socio-historical residue of these medieval anorexics may provide a contemporary justification for pro-anorexia, but pro-anorexia clearly does not take up where the medieval fasting saint left off.

[143] In his essay "Cyberspace and the World We Live In," Kevin Robins aptly—but somewhat facetiously—describes cyberspace as a "nowhere-somewhere." He writes: "you might think of cyberspace as a utopian vision for postmodern times. Utopia is nowhere (*outopia*) and, at the same time, it is also somewhere good (*eutopia*). Cyberspace is projected as the same kind of 'nowhere-somewhere'" (Robins, "Cyberspace and the World We Live In," 135 [emphases in original]). Robins goes on to interrogate the mythologization and idealization of virtual culture, raising suspicions about its promises of restorative community and unconstrained identities. He instead suggests that the notion of "virtual

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community . . . reflects the desire to control exposure and to create security and order. It is also driven by the compulsion to neutralize" (151). The links between virtual culture and "the real world" must be seriously reconsidered (153). It is with these caveats in mind that I take up his term "nowhere-somewhere" in relation to pro-anorexic discourse.

[144] This particular notion of the physical body as "meat" is generally traced to cyberpunk writer William Gibson. The abandoning of this "meat" is now taken up in cyberpunk culture as the "ultimate experience." For further discussion and examples, see, Balsamo, "The Virtual Body in Cyberspace"; Clark, "Rear-View Mirrorshades"; Haraway, "Cyborg Manifesto"; Robins, "Cyberspace and the World We Live In"; Stelarc, "From Psycho-Body to Cyber-Systems"; and, Stone, "Will the Real Body Please Stand up?".

[145] Lupton, "The Embodied Computer/User," 100.

[146] Ibid.

[147] Haraway, "Cyborg Manifesto."

[148] Ferreday, "Unspeakable Bodies," 277 (abstract).

[149] Balsamo, "Forms of Technological Embodiment," 219-20.

[150] See, for example, Leary, "The Cyberpunk"; Robins, "Cyberspace and the World We Live In"; and, Turkle, "Identity Crisis."

[151] See, for example, Rheingold, *The Virtual Community*; Robins, "Cyberspace and the World We Live In"; Willson, "Community in the Abstract".

[152] See Haraway, "Cyborg Manifesto," 150.

Conclusion

When I began this project, I intended to focus on Oprah and Foucault, and to explore how Foucault's notions of medicine, disciplinary normalization, panopticism and power pervaded Oprah Winfrey's multi-media messages of femininity to produce the postmodern cultural clinic. People would ask about my dissertation; Oprah would come up and the conversation would explode: "she's so annoying," "she's so far from reality," "she even interrupted Nelson Mandela," my friends complained. What most people wanted to talk about, though, were Winfrey's weight struggles. As her own weight fluctuated in a public media display, Oprah advocated numerous weight loss programs with strict daily diet and exercise regimes; connecting psyche and soma, she translated regulated discipline into individual empowerment. At the same time, however, Oprah vilified other feminized struggles with embodiment, such as the pro-anorexia movement and certain women's embodied experiences. Her message, in other words, reflected the broader cultural imperative of appropriate feminized embodiment, laden with contradictions and slippages. I realized that Oprah's multi-media discourse on weight loss was but one of many manifestations of the emerging discourse of the postmodern cultural clinic; and, I expanded my project to examine three case studies that exemplified different aspects of this convergence of medicine and feminine aesthetics in contemporary culture: the inpatient medical treatment protocols for anorexia nervosa spatialized this clinical discourse in a conventional medical setting fraught with the incongruity of a "feminized" disease; Winfrey's weight loss discourse represented a more everyday example, but one similarly complex in its treatments of individual empowerment and femininity; and, the pro-anorexia movement served as an extreme expression of the collision of medicine and feminine aesthetics, at once disdained and obsessively discussed in mainstream culture.

Foucault's wonderfully complicated ideas about medicine and embodiment threaded through these examples. In *The Birth of the Clinic* and elsewhere, Foucault argues that, as modern medicine developed, it gained legitimized knowledge of and authority over not only individual bodies, but also the social space between bodies.[1] With the simultaneous development of modern power regimes, medicine became a central mechanism of disciplinary normalization, one of the key regimes involved with the production of social regulation through individuals' self-policing to various social standards. As I have discussed throughout these chapters, numerous feminist theorists have identified the historically fraught relationship between medicine and women; and, many also argue that the impetus of disciplinary normalization is felt more strongly by women, at once demanding more stringent adherence to disciplinary standards and producing a distinctly inferiorized feminine body-subject.

In the contemporary moment, the postmodern cultural clinic signifies a new clinical discourse by which this feminized disciplinary impetus is both expanded and enhanced by its increasing medicalization. On the one hand, aesthetic standards become more resistant to critique when framed in terms of health. On the other hand, the aestheticization of health inextricably entwines disciplines of health with feminized disciplinary practices. In other words, it is not just that these two regimes are both distinctly focused on the female body, but that their particular convergence sharpens the punitive/productive force of both regimes in the lives of women.

The postmodern cultural clinic lays out terms of disciplinary femininity through its medicalization, with explicit prescriptives for "health" that invoke implicit proscriptives for appropriate feminized embodiment. Following feminist scholars such as Susan Bordo and Sandra Lee Barkty who argue that women internalize the disciplinary gaze, I argue that women specifically incorporate a now altered and multiplicitous medical gaze into their feminized identities. This gaze fuses disciplinarity and medical normalization with the productive force of the modern cinematic gaze (as identified by Denzin) and the objectifying acumen of Mulvey's masculinist gaze. Its practice expands the non-reciprocity of the clinical exchange, spatializing its simultaneous pathologizing and normalizing force into women's daily practices. Through this process, the postmodern cultural clinic is materialized through women's never-ending disciplinary practices; each fat gram passed over, each mile run on the treadmill, each self-defeating glance in the mirror spatializes the postmodern cultural clinic.

Such spatializations also reveal the contradictions of both disciplinary femininity and the postmodern cultural clinic. Empowerment and constraint are entwined in the control of the body through exercise and diet regimes. The impetus of health blurs with the coding of the thin feminine aesthetic as a hegemonic icon of whiteness, affluence and hetero-patriarchy, fusing both regimes with hegemonies of ethno-racialization, class and heteronormativity. And, while this cultural clinic at once expands and reinforces medical authority over the female body, the incorporation of the now altered medical gaze into feminized disciplinary practices also displaces the traditional space of the "clinic." This cultural discourse spatializes the clinic beyond the confines of the doctor's office and into the multiplicitous spaces of feminized identity. This convergence blurs the line between health and feminine aesthetics, again sharpening the disciplinary impetus of both regimes.

Each case study illustrates specific manifestations of this clinical discourse, and reflects its predominantly hegemonic reiteration of appropriate feminized embodiment. While empowerment and agency are enabled through this cultural clinic, they are recuperated into the reformation of the thin feminine aesthetic via "health" or, alternatively, dismissed as "unhealthy" and deviant. First, the inpatient medical treatment protocols for anorexia nervosa employ formal mechanisms of surveillance and routinization to control knowledge over the treatment process, maintain near constant surveillance of patients, and stringently regulate patient activities. Drawing a discursive analogy between Foucault's social panopticism and the medical panopticon that is constructed through these treatment regimes, I argue that these protocols discursively constitute women undergoing treatment as "anorexic patient/prisoners." Specifically, this "patient/prisoner" struggles with her own culturally constituted desire to overcome the "prison" of her unruly female body; she is pathologized for her efforts, drawing her into the prison of medical panopticism; and, once re/formed, she returns to the more subtle, though no less ever present, panoptic regime of normative femininity. The explicit goal of these programs is of course the wellness of patients; but, in a discursive sense, their medical panopticon of surveillance and routinization prepares women for the broader social panopticism of their everyday lives. Medical discourse translates normative standards of feminized embodiment into treatment outcomes, with goal weight and the return of menstruation signalling recovery. What the explicit disciplinary mechanisms of surveillance and routinization then share as an implicit goal is the return of this patient/prisoner to an appropriately disciplined bodily form.

In Oprah Winfrey's weight loss discourse, Winfrey herself serves as a kind of modern day everywoman, with whom women can identify in their struggles to lose weight. Through the reiteration of her own diet narrative, Oprah becomes an exemplar of women's "good health." Winfrey's numerous weight loss campaigns are framed in terms of women's empowerment through the control of their lives via weight loss, and in the medicalized terms of Winfrey's cadre of guest experts. Specifically, this weight loss discourse produces a socio-clinical televisual space, employing expert knowledge, prescriptions for wellness, quantifications of weight loss, and Oprah's own example to legitimize her campaign for women's health and wellness. Reflecting mainstream perspectives on "fatness," this televisual clinic also produces a proscriptive response to the "American obesity epidemic" through its treatment of both "fat" and "thin" experiences. Regarding obesity, Winfrey presents a contradictory message of acceptance of the struggles of her overweight guests and vilification of obesity.

By contrast, Winfrey constructs weight loss as a means to "live your best life," and thinness is particularly coded as a "reformed" body. It is not only a re/formed body, but also a new individual that emerges from this process. Despite its focus on individual acceptance and empowerment, Oprah's weight loss discourse reinforces a normative prescription for feminine discipline.

Finally, the webpages of the pro-anorexia movement reveal the paradoxical subjectivation of "pro-anas," and expose these women's embodied, very material struggles with normative femininity. Their volumous discussions and debates reflect what Susan Bordo has argued about eating disorders more broadly: conformity and rebellion exist in the same gesture.[2] For instance, the medicalization of eating disorders is a central theme that participants simultaneously embrace and disrupt. On the one hand, they specifically construct their identities against medical pathologization; and, many pro-ana sites also detail how to deceive physicians by hiding their practices. On the other hand, participants extensively discuss ways to maintain their health, employing medical knowledge to sustain their practices. In multiple ways, pro-anas both usurp and disrupt the medical gaze. The movement also enables the troubled "speech" of its participants, who are largely silenced in mainstream culture. Paradoxically, participants voice their struggles with feminized identity by entering into the disembodied space of the internet and effacing their own identities. They participate anonymously and pseudonymously, taking on the identity of "ana." Neither their identities nor their bodies are stable in this virtual clinical space;

and, these slippages produce a doubled disappearance by which pro-anorexic discourse exposes the vacuous foundations of the thin feminine aesthetic.

Overall, these three case studies highlight the multiplicitousness of the postmodern cultural clinic as it erupts in diverse cultural sites with multiple messages of feminized bodily conformity. The convergence of medicine and feminine aesthetics, then, cannot be simply identified as a single regime or a single set of practices. Instead, the postmodern cultural clinic involves the convergence of multiple, changing and often contradictory demands in the lives of women.

This productive instability does enable practices of agency and resistance, even if these practices are continually recuperated into the dominant cultural messages of the postmodern cultural clinic. For instance, practices such as such as water loading and the weighting down of clothes before weigh-ins resist the discipline enforced in anorexic inpatient treatment settings. Within the discourse of inpatient treatment, this resistance prompts ever more stringent mechanisms surveillance and routinization, as patients involved with such practices are labelled as deceitful by physicians. While Oprah's weight loss discourse reinforces dominant cultural messages of feminized embodiment, her "boot camp" participants find renewed voice and empowerment in their weight loss efforts, regardless of how temporary or suspect this empowering rhetoric of "health" may be. Pro-anas overtly and deliberately skew the authority of the medical gaze, their identities and practices themselves symbols of resistance. Yet, their violent speech is repeatedly silenced by public protest and the power-laden language of "disgust" and "disease." The power/knowledge apparatus of medical authority both informs these disruptive practices and becomes the mechanism by which they are recuperated into the hegemonic terms of the postmodern cultural clinic; the regulatory impulse of this clinical discourse ensures that both conformity and resistance will be reformed into a renewed feminine aesthetic enhanced by the medical power of "health."

Moreover, each case study reveals the complex and often contradictory cultural construction of the "fat"/"thin" binary and its entrenchment in the medicalized discourse of feminized embodiment. Across these cultural texts and sites, a reformed feminized aesthetic emerges from the never-ending disciplinary practices required of individual women. The thin aesthetic is simultaneously the "cause" of anorexia in inpatient treatment protocols, and a benchmark of appropriately reformed feminine behaviour. While the thin aesthetic is made more palatable in Oprah's televisual clinic, infused as it is with the virtue of health, pro-anorexic discourse exposes the thin aesthetic as a mechanism of social control, reading it as both sign and signifier and, thereby, rendering it unpalatable in its pro-anorexic form. In these various manifestations of the postmodern cultural clinic, the feminine aesthetic becomes a signifier of "health" that is simultaneously erased and invoked by thinness.

Having finished this project, I am still left with many questions. At the beginning of this work, for instance, I refer to a curious paradox that emerges in these three examples of the postmodern cultural clinic: they each rely on and erase particular women. On the one hand, as exemplars of the postmodern cultural clinic, they are directed toward actual individual women entangled with the disciplinary regimes of medicine and femininity. On the other hand, they are discursive, hegemonic texts that neither rely on nor speak to any singular or particular woman; their hegemonic constitution ensures their broad applicability, thus culling more women and more women's practices under their disciplinary impetus. As such, these examples expose a slippage between actual women's lived experiences and the discursive prescriptives of the postmodern cultural clinic. This absencing marks these texts as hegemonic, discursive apparatuses that invoke the regulatory terms of their constitutive regimes. What, then, is the status of individual women who are simultaneously central to and silenced in the regimes that subjectify them in particular ways? Put another way, what happens in the absences and silences that are constitutive of this clinical discourse and that prompt its reiterative prescriptive impetus toward health? In terms of my analyses, who are the actual women undergoing inpatient treatment for anorexia, those who manipulate the terms of their treatment contracts to sustain their "diseased" practices or those who recover only to return to the panoptic regime of normative femininity? Why are women whose struggles end in mortality statistics (marking anorexia as one of the most deadly psychiatrized illnesses) given no acknowledgment in the treatment protocols that failed them? Where are Oprah's "failed" weight loss campaign participants, who never make it to the "after" frame, never celebrate with Oprah onstage, never lift the veil of fat that is smothering their "true selves"? And, what happens to the numerous faceless, disembodied girls and women whose only representation to the world (at least in their shared online identity) is the textually mediated voice of pro-anorexic websites?

Beyond this project, what of the women's experiences that are not represented in these examples? Entwined with the hegemonies of ethno-racialization, class and heteronormativity, the reformed thin feminine aesthetic of the postmodern cultural clinic is marked by whiteness, affluence and hetero-patriarchy; and, only a handful of examples in my case studies challenge this construction. Does this discourse then only speak to women who more closely align with this ideologically infused representation? Or, do women othered by this dominant representation mediate its regulatory impulses differently? As the postmodern cultural clinic materializes in diverse cultural sites and reiterates the contradictory messages of appropriate feminized embodiment, the myriad representations of this clinical discourse that are not explored here would certainly reveal additional—and important—complexities in its discursive manifestations. As such, these women's experiences represent vital areas for future study.

As well, the reiterative cultural narrative of women's insufficient embodiment will undoubtedly produce new prescriptives for appropriate feminized identity that will push the regulatory mandate of the postmodern cultural clinic ever further into women's lives. New medical technologies will "discover" new sites of embodied failure, and the shifting cultural representations of the thin feminine aesthetic will produce yet more exemplars of disciplinary femininity. As these emerge, the non-reciprocity of the clinical exchange will again spatialize the punitive/productive force of the altered medical gaze beyond the space of the traditional "clinic" and into the various sites of feminized identity. What this signals is that the social demand for particularized, disciplined feminine embodiment can no longer be dismissed as an issue of aesthetics and vanity, as its negotiation in individual women's lives is now irrevocably altered and complicated by its insinuation with the contemporary medical rhetoric of health.

Notes

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[1] Armstrong, *Political Anatomy*, 6.

[2] Bordo, "Reproduction of Femininity," 174-77.

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Appendix I:

University of Alberta Arts, Science and Law Research Ethics Board Certificate of REB Approval

UNIVERSITY OF ALBERTA

Arts, Science & Law Research Ethics Board (ASL REB)

Certificate of REB Approval for Fully-Detailed Research Proposal

Applicant: Mebbie Bell

Supervisor (if applicable): Dr. D. Aoki

Department / Faculty: Arts, Sociology

Project Title: The 'Pro-Anna' Movement

Grant / Contract Agency (and number):

(ASL REB member) **Application number**: 668

Approval Expiry Date: June 24, 2005

CERTIFICATION of ASL REB APPROVAL

I have reviewed your application for research ethics review and conclude that your proposed research meets the University of Alberta standards for research involving human participants (GFC Policy Section 66). On behalf of the *Arts, Science & Law Research Ethics Board* (ASL REB), I am providing expedited research ethics approval for your proposed project.

Expedited research ethics approval allows you to begin your research with human participants, but is conditional on the full ASL REB approving my decision at its next meeting June 24, 2004. If the full ASL REB reaches a different decision, requests additional information, or imposes additional research ethics requirements on your study, I will contact you immediately.

If the full ASL REB reverses my decision, and if your research is grant- or contract-funded, the Research Services Office (RSO) will also be informed immediately. The RSO will then withhold further funding for that portion of your research involving human participants until it has been informed by the ASL REB that research ethics approval for your project has been granted.

This research ethics approval is valid for one year. To request a renewal after June 24, 2005please contact me and explain the circumstances, making reference to the research ethics review number assigned to this project (see above). Also, if there are significant changes to the project that need to be reviewed, or if any adverse effects to human participants are encountered in your research, please contact me immediately.

ASL REB member (name & signature): K. Haggerty / R.

Date: June 25, 2004

May 1, 2003